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Health and Equity - Effecting Change

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HEALTH AND EQUITY - EFFECTING CHANGE

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Technical Report Series

This Technical Report Series is part of the Hivos-India Regional Office's effort to participate actively in the debate and dialogue in India on issues of human development and emancipatory interests. This series consists of monographs, working papers and Hivos conference proceedings. The publications reflect policy concerns of Hivos regarding development issues in India and address the problems faced by the marginalised in developing countries, such as in the areas of human governance, environment, gender, culture, the politics of development, human rights, information and communication technology, and economic activities.

Series Editor: Shobha Raghuram

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HEALTH AND EQUITY - EFFECTING CHANGE

Preface

This publication of the **Hivos Technical Report Series** 'Health and Equity - Effecting Change' is being released at a time when several changes are occurring globally- the rapid changes that globalisation has brought on to national economies, the growing destitution of vulnerable populations in many countries, and the multiple burdens of ill health and poverty for the poor. For the many who have been engaged in development work and who have indeed spent considerable time on health issues of the poor, constructing on the field viable alternatives for the poor in accessing health care, who have sensitised governments to respond more effectively to the health needs of the marginalised or have acted as allies in the struggle for equal care, it has become a time for taking stock of matters as they stand and for assessing the nature of the concerns, the contours of the crises, and the responses that are required. The Workshop on **"Health and Equity - Effecting Change"** jointly organized by Hivos, FRCH and IIMB, to be held on 9-10 Nov 2000 at the Indian Institute of Management, Bangalore was to have preceded this report. Due to the political turmoil in Bangalore during early August this year, when the conference was originally scheduled, the Workshop had to be postponed and the report now precedes it!

This report provides a platform for committed development practitioners with common concerns, but not necessarily with similar approaches, to come together in policy debates, the sharing of case studies, presentations with unique perceptions across locations and constituencies. Several activists, policy makers and community

health workers will attend this Workshop to search for strategies which effect changes in reducing the growing imbalances in health care. Hivos has been working on the issue of the roles of the state and civil society in the issues of equity for the poor during the last few years, especially in cooperation with its partners. Hivos organised a workshop on Reproductive Health Rights in collaboration with the Coordination Unit, Bangalore and The Centre for Reproductive Law and Policy in New York in 1995. The publication that followed 'Rethinking Population' was used in the Beijing consultations by NGOs to lobby with governments and also became an effective resource document for training.

This Hivos Technical Report is part of the Hivos-India Regional Office's effort to participate actively in the debate and dialogue in India on issues of human development and emancipatory interests. It enjoys a wide circulation among Hivos partners in India and globally, among development workers, policy analysts, concerned government departments, development cooperation institutions, and independent development writers.

The last 51 years of development history for India have shown the limits to policy, and the greatest need for consolidated social and political action taking place at the most micro-levels and at the same time the need to evaluate national governments which, in the larger sphere of state role advocate policies which sometimes undermine other human development efforts. Historically, after independence, the government, in response to the large numbers of poor in unequal health circumstances, made many committed pronouncements pertaining to improving the lot of the vulnerable in the official planning processes. The 1978 'Health for All' Declaration received a full-fledged commitment from the Indian government and this was important in order to propose a broad and consistent philosophy towards a strategy secured in the primary health care PHC approach.

Today, an examination of the status of health indicates that there is surprising unevenness across borders. In addition to the rural/urban divide, the caste, class and gender disparities in health persist, giving rise to a situation in which different pockets of population within the same country portray differing health status. The availability of access to social infrastructure is uneven between social groups, economic classes and geographical regions. The scheduled classes and tribes, in particular, and the poor, in general, are being adversely affected. Health problems associated with underdevelopment (among people living in poverty and the disadvantaged) and the extent of transitions which are creating a

'polarization' of health between different groups have been the grounds for public action. For policy-makers designing appropriate policy but also measuring the benefits of competing health investments on different groups of population is critical.

Effecting changes which are visible is a challenge. Health is a social claim, and unless we pinpoint the gaps and find solutions for the structural imbalances we cannot create those dimensions which will carry forward the necessary transformatory processes. In these pages committed activists deliberate on how to bring about changes. Through these dialogues social actors in health may further deepen their alliances and cooperative in bringing about effective change. The upcoming People's Health Assembly Meeting Dhaka is a testament of the will in the public to reform health systems for better meeting the needs of the people.

This report has been divided into four sections and contains 13 papers in all and 5 case studies. The 4 sections include Public health in India: Its development and Challenges, Civil Society Partnerships: Examples from the Field which includes Case Studies, Health Financing and Health Care and Ethics. The writers all have one thing in common- years of experience in the sector of public health, advocacy and the practice of alternative health care systems. The issues span a large canvas and we list out some of them.

I. *Globalisation and Role of the Nation State (Global Context)*

- In the context of globalisation, the generally accepted roles of the state and private actors in provision of health care.

- Increasing reliance on the market forces/mechanisms to address welfare needs (health, education, housing and shelter, food security) of the people. In particular, what is the perceived role of the state and its responsibilities with regard to health

- primary and tertiary services, health care education, etc. What have been the effects of minimizing the role of the state in fulfilling the welfare needs?

- What have been alternative institutional forms/roles / structures in meeting the health needs? What are the regulatory / controls mechanisms?

- What other institutional forms are required to make public health delivery effective? What would be their roles?

- What could be the role of the Civil Society in meeting the responsibilities of the health sector?

II. The India Experience

- With the onset of Globalisation and the New Economic Policies in the 90s, how have the income inequities impinged on the health status? In particular, what impact has it had on different constituents – with reference to disparities in regions, class, caste, gender etc?

- How has the emerging market on health care products and services affected the access to health services by the poor? Would the introduction of user financing in health sector deliver services in an equitable manner? Who will take care of those who cannot pay?

- How effective have the health policies been in delivering health services in an equitable manner in the past and in particular in the '90s? Do the health initiatives supported by the State in the 90s in accordance with the epidemiologic and demographic transition in India? Finally, what is the role of government in financing health services?

We would like to thank our collaborators/ partners for their contributions and in particular Dr.Antia, Gita Sen, Thelma Narayan, and Dr.Srinivasa Murthy who gave us the necessary support and guided us for the key issues. To Wendy Hartcourt of SID I owe a special thank you as she initiated me into the global dialogues on these issues by enabling my participation in the international colloque on 'Responses to Globalisation: Rethinking health and equity' in collaboration with WHO, June 1999. I would also like to thank the Director of Hivos, Dr. Hannah Piek and the staff of Hivos Regional Office for all the assistance. Hemalatha in particular deserves a special mention for all the communications to the authors, the several drafts of editing and the total commitment with which she stood by the process. We do hope that this volume will record the nature of the processes within healthcare in reaching equity and will fulfil the need to take that history to a wider audience.

Shobha Raghuram
Hivos Regional Office,
Bangalore.
24 October, 2000

Section I

Public Health in India: Its Development and Challenges

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Equity and Health

N.H. Antia

Human history is replete with examples of the struggle between the two contradictory traits of human nature which differentiate us from all other species. At one extreme is greed which demands instant gratification regardless of the long-term consequence to self or others. And yet all prophets and wise men have preached the suppression of this unfortunate trait which leads to unhappiness and which now poses a threat even to the long term survival of our own and other species.

Health in its wider concept covers a gamut of social and economic aspects of human activities such as nutrition, education and environment. Hence attempts at improving health by focussing on an individual component such as curative medicine can only serve as a temporary patchwork arrangement without appreciation of the many other factors and above all of the socio-political forces which underlie both health as well as illness care. The following examples will help to illustrate this.

In 1846 Rudolf Virchow,[1] a German physician, raised the issue as to why the health of those who worked in the mines of Silesia was worse than that of the citizens of Berlin. He also stated that

1. Virchow Rudolf, "**Collected Essays on Public Health and Epidemiology**", Vol.1&2, Ed., L.J.Rather, 1985.

"medicine is a social science and that politics is the practice of medicine on a larger scale".

The study of health in the UK from the feudal to the industrial, imperial and socialist stage to the present neoliberal capitalist phase provides an interesting insight into the role of changing socio-political influences on the health of the people. The onset of the industrial revolution resulted in large-scale migration of the rural population to urban industries in search of employment. This not only disrupted the human relationship, however tenuous, between the feudal landlord and his tenants but also moved the workers from a relatively healthier rural environment to the sordid unhealthy slums provided by single-minded profit oriented industrialists. The workers had little choice. The appalling conditions in the early phases of unregulated industrialization have been vividly described by Dickens. The response was not improvement of the workplace as described by Owens and the home environment by implementing the sanitary reforms of Chadwick, a city engineer, but its rejection by the city fathers as a waste of public funds. The medical profession preferred that the money be used to support larger public medical institutions called Infirmaries where they could learn and practice curative medicine as a form of charity, while enjoying the rich pickings from the care of the affluent members of their society. It was the fire of London that burnt the unhealthy rat infested slums resulting in the control of plague; not the medical profession. The military aspect of the same industrial revolution also led to sudden increase in the country's wealth as a result of colonization of countries like ours. Even a minor trickle-down effect of this wealth resulted in improving the conditions of the working class despite increased polarization of their society. Marx predicted the conflict inherent in such a situation, where the working class which had risen above grinding poverty would now organize to fight for social justice. While the predicted revolution did not occur in the UK, the impact of even a modest alleviation of poverty and consequent improvement of working and living conditions was evident in its dramatic effect on tuberculosis. Macewan utilizing data provided by the registry of deaths per disease maintained in Britain since 1860, showed the dramatic regression of this disease even before identification of its causative organism by Koch in 1882 and tuberculosis virtually disappeared in the UK before the discovery of vaccines or drugs; a clear demonstration of the dramatic effect of even minor improvement in socio-economic changes on this as also on other communicable diseases resulting from poverty.

The two internecine wars fought in the first half of this century by the European powers for each other's colonies also demonstrated two entirely different effects on health of these countries. The

economic depression of the 30s and the effect of devastation of the countries of Western Europe like Holland in the early 40s resulted in a massive resurgence of tuberculosis And yet no sooner than the economic conditions improved as a result of political programmes like the Marshal Plan, tuberculosis vanished within a few years and the hospitals and sanatoria had to be closed. This also demonstrates that the control of the diseases of poverty also lies primarily in the field of political and social action and not that of hospitals, doctors or of medical science, which are only supportive services.

And yet it was the result of these two wars that brought about a radical change in the health of the people of Europe, as seen today. The use of the workers as cannon fodder by the ruling classes of all warring nations also helped to raise their consciousness and demand for their rights as equal citizens in so called democracies. This egalitarian upsurge is reflected not only in the postwar unification of Europe but also in the dramatic overall improvement of their economy which is also reflected in the health of its citizens. To them health is no more an act of charity but a basic right of all citizen as for education, employment, food security and welfare regardless of class, gender or economic status. The immediate post war installation of the Labour Government in the UK resulted in the implementation of the Beveridge report in both its letter and spirit even though this was one of the darkest economic period of that country's history. The dramatic change that ensued in health which resulted despite shortages of food, clothing, housing and basic necessities, once again demonstrates how good health as well as good medical care can be achieved at remarkably low cost when the necessary political will is manifest for an egalitarian society based on sharing and caring.

And yet the Thatcher government, under the tutelage of the US, succeeded in backtracking in many areas of the country's post-war socialist egalitarian form of development including an attempt to privatize health. Yet it was the conservative British Medical Association which had opposed the National Health Service (NHS) in 1947 who now stoutly supported the people in refusing to dismantle the NHS. The Black Report of 1980 also revealed how the health inequalities had widened during this period. This was also an important reason for the reinstatement of the Labour Party. The renewed attempt of the present Labour government under the tutelage of the US policy of globalization, liberalization and privatization has also been strongly opposed by the people in the field of health, education and welfare. A recent report shows how the infant mortality in the industrial cities like Glasgow and Liverpool is twice as great as in the home counties. This also reveals the high priority that the people at large assign to health

and medical care as a social right which once enjoyed they refuse to part with.

In contrast the US as the citadel of private enterprise has given almost unrestricted liberty to the private sector operating for profit even in the field of health which is an area where consumer resistance is at its lowest. Spending 14.5% of its GDP amounting to well over one trillion dollars or $ 4409 per capita per annum, it provides a service which is far inferior to that of the UK and other capitalist countries of Europe spending 9% of their GDP. Far worse is that 45 million (15%) of its citizens have no insurance coverage for health and medical care and have to depend on a service that resembles the Infirmaries of the UK which existed two centuries ago.

The USSR, Cuba and China starting with a virtual non-existent health and medical care service demonstrated how rapid strides could be made in both fields within a decade of achieving independence. Like Nicaragua, they were able to achieve remarkable improvement in education, health and welfare even while fighting on several fronts for their country's very survival. Sri Lanka and Costa Rica as non-socialist states have also demonstrated how similar results can be achieved when the national social conscience and political will is high. Kerala a socialist state of 30 million despite being a part of a larger non-egalitarian democracy has shown remarkable results in education, population control and health despite a low level of economic development. Spending about $ 25 per capita per annum on health it has an IMR of 13 and a general health status which is not far behind that of the US with an IMR of seven. These examples clearly demonstrate that the health of the people of a country depends far more on its political organization rather than on the expenditure on health and medical services that it incurs. Health is above all a function of the social commitment and political will which also affects the efficient functioning of the medical services. It also demonstrates that good basic health and medical care can be provided to all citizens at remarkably low cost while there is no limit to expenditure on curative medical care when it is converted into a commodity for sale in the private market place.

We shall now try to examine the effect of changing socio-economic and political forces on the health of the people of our own country from the Pre-British, British to the Post Independence period in the last five decades.

Although no detailed information is available on health of our people in the pre-British era we have documentation of the existence of an advanced civilization about 5000 years ago in the Indus valley which had extended to what is presently northern Gujarat. The excavations at Harappa and Mohenjodaro reveal remarkably well-organized habitations including existence of baths and

management of water and sanitation. In the following period of Indian Renaissance which was about 2500 years ago, there emerged philosophers like Mahavir and Buddha and rulers like Ashoka. This period was also associated with advances in the science of health as well as of medicine and surgery. These have been recorded in the samhitas of Sushrut and Charak. Though chiefly patronized by the elite in the subsequent millennia this knowledge of health has become an integral part of the life and practices of Indian society at large even to this day, often expressed in the form of religious practices and rituals concerning food, hygiene, exercise and social behaviour. Together with extensive knowledge of home and herbal remedies this has played an important role in sustaining the mental as well as physical health and well-being of the vast majority of our people even during the subsequent difficult periods and even to this day. Not being dramatized and commercialized or enjoying political patronage like Allopathy, we have failed to appreciate the role of these advanced indigenous systems in sustaining the life and health of our people despite severe deprivation.

The writings of Bernier, Dubois and Adams reveal that the provinces of Bengal, Bihar and Orissa were the richest in India and had the largest hoard of gold and silver in return for the sale of produces like jute, muslin, indigo and opium. Bishop Reginald Heber also records that at that time 'local women were as tall as European women'. Jaffar in 1765 records how the economy of these provinces was ruined by firemen of the Mogul Emperor which permitted the East India Company the duty free import and export of goods. The Company freely issued permits known as 'dastaks' which ruined the age old business industries leading within 15 years to the 'dastak famine' of 1769-70 which according to Hunter resulted in the death of 1/3 of the population of this region.

This systematic loot of the wealth of our country has been well documented by Dadabhoy Naoroji and others. Except for a few favoured elite and the sepoys of their army, the impact on health of two centuries of foreign domination has been demonstrated by the life expectancy of 20 years as recorded in the 1911 census. As a result of the pressure of the Congress movement and health being transferred to local state ministries there was certain improvement as reflected in the census of 1941 when life expectancy had risen to 32 years. A further marked improvement in life expectancy to 46 years was achieved by 1961 as a result of Independence. This has now reached 60 in the 1991 census.

The dramatic improvement in the first two decades following Independence was demonstrated by the eradication of smallpox, almost near elimination of malaria from 100 million to less than 100,000 cases and control of cholera and plague-the four major scourges of the pre-

independence period. What is even more remarkable was that this was achieved with the then available simple medical knowledge and technology, very limited financial resources, and only a handful of dedicated public health officers. This was possible only because of sustained support by a strong political will to ensure that the benefits of Independence should reach all those who had struggled for achieving Independence. There was also an equally enthusiastic response by the people themselves who had participated in the struggle.

And yet the improvement in the following two decades is nowhere commensurate with what was achieved by China during the same period using the decentralized 'barefoot' approach. China's life expectancy in 1991 had reached 70 years as compared to 60 of our own. The deterioration during this period was despite the availability of vastly improved medical knowledge and technology as also of medical manpower and infrastructure. Unfortunately unlike China after the first flush of independence the Indian scene was increasingly monopolized by an increasingly self centered political leadership supported by an equally over-centralized, over bureaucratized, over-westernized and over-urbanized public sector which further alienated rather than encouraged the involvement of the people in their own health and medical care. These decades also resulted in massive proliferation of the profit-oriented private health sector interested in lucrative curative medicine but not in preventive or promotive aspects of health. This was in conformity with an increasingly polarized society controlled by those whose single-minded interest was on creating a lucrative milieu for a small elite segment of our society, living in urban enclaves, and, whose desire in 'health' was for the 'latest' expensive curative medicine as practiced by their US mentors rather than even the more socialist UK model. This has been reflected in all aspects of our country's development during this period. This was despite India adopting the democratic mode of development but where the majority of the people were marginalized and deprived of education and information with the consequence that they had little say, leave aside influence, in decisions affecting their own welfare.

The statistics that have been provided by the government are almost invariably of an aggregate nature. In a highly polarized society this conceals more than what it reveals. In 1997, Kerala[2] had an IMR of 13 while in the UP it was 85 while the All India figure was 71. Such figures generated in backward states under political and bureaucratic pressures are even more suspect. Aggregate urban statistics inform

2. UNDP, **"Diversity and Disparities in Human Development: Key Challenges for India"**, UNDP, New Delhi, 1999.

us that urban health is twice as good as that of the rural areas. And yet it fails to reveal that the statistics of half of the urban population comprising of the upper classes has a health status equivalent to that of the affluent West, while that of the slum dwellers who comprise the other half of the urban population is as bad or even worse than that of their rural counterparts. The remarkable achievements in education and health in Kerala is more the result of education of women rather than of medical services; also that these statistics are reflected uniformly in all districts of this state. In contrast the infant mortality of the poorest families of the poorest villages of the poorest district in the backward BIMARU states is probably in the region of 500 where every second child that is born dies before reaching the age of one year. No wonder the Family Planning programme in Kerala has to emphasize that non-terminal methods of contraception should be practiced till their two children reach the age of 5 years. On the other hand the poor in the BIMARU states know that a hostile political and bureaucratic system considers them only as a population threat which dilutes the gains of development, without providing even basic subsistence and health care during illness and old age. It is conveniently forgotten that under such conditions these families need eight children for mere survival leave aside deserving of some love and affection in an increasingly hostile world.

This marked change in the approach and direction to health and medical care following the first two decades after Independence has been in keeping with the overall change in the political will among the subsequent generations of our leadership often based on dynastic considerations. The change was from an egalitarian to a more selfish approach designed by and for the benefit of a small 'creamy' layer which has siezed the reins of power. This has been at the expense of the masses who had fought for the country's Independence under the dedicated leadership of those like Gandhi, Nehru and Patel. The shift in health was from an egalitarian 'Health for All' to 'Wealth for a Few'. This change in national development to a capitalist form of governance under the guise of representative democracy, has also adversely influenced its health policy, which in turn has been influenced in no small measure by the western powers led by the US.

This was responsible in transforming the integrated health and basic medical care approach of the Bhore Committee designed[3] for a predominantly rural nation

3. Government of India, **"Report of the Health Survey and Development Committee"**, Government of India Publication, 1946.

with limited capital but unlimited human resources, to one based on the latest expensive high technology for the urban rich. This was the result of willing cultural and economic co-option of the dominant elite by the West which had increasingly become their role model of success.

Following the collapse of the USSR in the early 90s, including that of its remarkable health and medical facilities, the same strategy has been utilized in an even more aggressive form for neocolonization of the newly independent 'need based' countries by utilizing the same economic and cultural weapons devised as early as 1948 at Bretton Woods for redomination of the world. Under the guise of globalization, liberalization and privatization these agrarian Asian economies were artificially converted into a state of Western style industrialization by provision of extensive loans. Using the rich local natural resources and cheap labour by corrupting the local leadership this not only polarized their societies and created social disruption but reduced them to a state where their trade and even the mode of governance could then be dictated by the US and other Western multinationals in search of quick profit, regardless of the pauperization of the majority of their population; A replay of the previous five centuries of global exploitation through a form of 'trade' dictated by the European powers but now using a subtler technique than the crude gunboat diplomacy of the past.

Beginning with industry this has now extended to the service sector. In a globalized market place there is no better field for exploitation than health, since it is an area where consumer resistance is at its lowest. The socially, culturally and economically overawed and corrupted elite leadership, who control the levers of power, have proved easy prey to the systematic assault mounted by the pharmaceutical and medical instrumentation industry which has distorted the values and ethics and even corrupted the age old medical profession. This is a part of the undermining of the values, morals, ethics and practices of older civilizations by aggressive promotion of the baubles of mindless materialism generated by Western science and technology with Mamon as the reigning deity. Advanced systems of health and medical care like Ayurveda and Yoga which have sustained the health of our people over the ages have been systematically denigrated as being 'unscientific' unless validated by Western scientific paradigms or converted into marketable commodities. While ISM and Homeopathy are provided lip-sympathy by our own government, they receive less than 4% of the national health budget.[4] The

4. Government of India, Ministry of Finance, "**Economic Survey 1998-1999**", Economic Division, Ministry of finance, Government of India, 1999.

production marketing and consumption of drugs[5] and pharmaceutical starting at Rs.10 crores at Independence has now reached a mind boggling Rs.25,000 crores which now comprises over 50% of the overall expenditure of our country on 'health' which at 3.5% of the GDP is equivalent to Rs.54,374 crores. More than three quarters of this excessive production is consumed by the private health sector which ranges from 5-star hospitals and nursing homes to doctors roving the villages on motorcycles, providing unnecessary expensive and even dangerous injections and medicine to those who pay under duress of pain, suffering and death. This is the result of undermining of the public health sector by political and bureaucratic interference and a further 'cut' of 20% of its budget imposed by the IMF, the sister concern of the World Bank, under the guise of the Structural Adjustment Programme. Combined with the implementation of Fifth Pay Commission's recommendation, over 90% of the public health sector budget is utilized in paying the salaries of staff. After[6] imposing such sanctions further loans are freely offered by international 'usurers', and equally willingly accepted by our government, for facetious programmes like DOTS for tuberculosis, impregnated bed-nets for control of malaria and for building and equipping PHCs when the failure of the existing ones is the result of bureaucratic interference, inefficiency and lack of motivation and accountability to the people. The importing of highly expensive diagnostic, medical and surgical equipment, most of which is inappropriate for our country and its economy is in a stage of obsolescence. Such 'health' care promoted and welcomed by our elite now presents another lucrative avenue for multinational business and industry. Even the poorest are not spared since increasing poverty and its associated illnesses are now diverting almost 20% of their meager household expenditure from food to such inappropriate form of medical care. We are now told that the answer lies in handing over the ailing public assets like hospitals and PHC to the 'more efficient' private sector, together with the recurring expenditure. This privatization and appropriation of public assets by a sector well-known for its predatory instincts and practices is another bonanza for those who seek to enjoy the benefits offered by the globalized market. The privatization of health insurance now offers another avenue for such trade in human suffering. Surely, those who dictate such policies from Washington know the evils of converting people's health into a business and industry from the experience in their own country.

The effect of this latest assault by a combine of international and national

5. Phadke Anant, "Drug Supply and Use: Towards a Rational Policy in India", Sage Publications, New Delhi, 1998.

6. Rao Sujatha, **"Financing of Primary Health Care in Andhra Pradesh: A Policy Perspective"**, Centre for Social Services, ASCI, Hyderabad, 1997.

governments, organizations and agencies is demonstrated by the rapid deterioration of the health of our people during the present decade and the dramatic resurgence of diseases which had been controlled such as water-borne diseases like cholera and typhoid, vector borne diseases like malaria, filariasis, kalaazar, dengue, encephalitis and plaque and diseases of malnutrition such as tuberculosis and ARI. This has occurred despite vastly increased financial inputs which evidently are of the wrong type and resulting in demand for further loans which increase international indebtedness and imposing of further 'conditionalities' by IMF; an unending vicious cycle. In such a form of health and medical care the rich are dangerously over-investigated and over-medicated, the middle class pauperized when they fall ill, and 'health' services are diverting scarce resources of the poor from nutrition to medicines, doctors and drugs. Malpractice has assumed proportions unbelievable only a few decades ago. The urban poor living in slums suffer from a double burden not only of such diseases but in addition those of pollution of air, water and food. Even the rural population suffers from poisoning as a result of excessive promotion of pesticides and fertilizers.

Instead of addressing the specific health problems of our country and its people at large following Independence we are being dictated by international organizations and their itinerant experts from Geneva and Washington; some with good intentions though distanced from the reality of 'need-based' countries, while others have different motives and agendas of their own. AIDS provides a good example of the endless stream of vertical programmes imposed on our Ministry of Health and Family Welfare without consideration of local social, economic and cultural realities, which are far better understood by our own experts who are sidelined if their opinion does not support the advises of the 'aid' providing donors. Their advice based on limited Western experiences is in start contrast to the integrated approach necessary to solve such problems. Over 400,000 deaths have occurred annually in India for the past 50 years. Yet it has remained to AIDS with a few thousand annual deaths, a disease coming from the West, to draw attention to the far greater national problems of tuberculosis which is also essentially a disease of poverty. Even concerning HIV/AIDS the creation of mass hysteria by the use of modern mass media can only create more fear than awareness. Like leprosy another stigmatizing disease of which India has ample experience, it has been shown how such propaganda can drive such diseases underground in their early stages. The almost hysterical propaganda of AIDS promoted by the West with generous loans has resulted in increasing the stigma to tuberculosis with which this disease is now associated in the public mind. This can hence even hamper the control of tuberculosis. Substantial loans are now

provided for such ill-conceived programmes which can only sink the country into further international debt without any significant impact on our people's health and can only result in further increase the diseases of malnutrition and poverty.

The control of the diseases of poverty does not lie in the present spate of vaccines that are being devised in Western laboratories which when available for diseases like hepatitis, fail to reach those most in need because of cost combined with a grossly ineffective mode of its delivery. The most desirable vaccine for controlling the diseases of poverty is a vaccine against poverty itself which can be achieved only by a concerted international political will for an egalitarian form of world order of which health would be a major beneficiary. Though poverty has been created by the global policies of the West, we are informed by them that there is no means for curtailing this. What is worse is that the diseases created by such poverty are also converted into another lucrative business and industry by their multinationals.

The role of politics in our country's development and its effect on health was clearly visualized by Gandhiji both before and after Independence. While the illiterate masses stood by him in the struggle against British rule, he foresaw that despite the Trusteeship concept, those educated elite who had sat on the fence during the struggle and who would gain the reins of leadership and power in the next generation could not be implicating trusted to look after the interest of the masses in Independent India. His remarkable vision based on an uncanny understanding of human nature made him ensure that the ultimate power be vested in the hands of the people themselves in the form of the vote by incorporating Universal Adult Franchise in the constitution; this despite the apprehension and strong objection of the educated elite. After 50 years of a tortuous course of events during operation of the Representative form of democracy, the people of this country (as opposed to most other countries who gained Independence during the same period and opted for democracy) have been able to exert the power of their vote which has enabled them to achieve Panchayati Raj as perceived by Gandhiji. This is now a constitutional right, through the enactment of the 73rd and 74th Constitutional Amendments in 1993. The health of our people will ultimately depend on the outcome of the ongoing struggle which may be justifiably called the 'Third Struggle for Independence' whereby the people will regain their power and rights which have been appropriated by their elected representative under the guise of Representative Democracy. This can be achieved only through Panchayati Raj which is the only true form of democracy viz. Participatory Democracy. The Right to Information and even Right to Recall deviant elected leaders is being sought by the people who are now increasingly aware

of the importance of the power of their vote for regaining their economic and social independence. They are no longer willing to accept development in the existing form of urban industrialization imitating the western model which produces consumer goods and services for the elite when there is ample evidence that rural small scale agro-industrialization is far more humane as well as cost-effective and whose benefits accrue to the people at large and not to a select few. A form of development which is also compatible with Education and Health for All.

Despite adopting a westernized model, the Bhore Committee's report was the original concept of equity in health and medical care for all citizens and was adopted by the founder fathers as the model for our country's health policy following independence. Though India was a signatory to the WHO Alma-Ata Declaration of Health for All in 1978, the mere signing of the declaration had little if any impact on our health policy or its implementation. This was because by then the political will of our leadership had already changed to a more selfish objective of the succeeding generations of elected politicians. This noble declaration of Health for All was used by India, like most other signatories, as a convenient rhetoric to dupe their people while health was converted into a marketable commodity to serve a select few of their citizens. Even WHO itself soon converted this holistic and integrated concept of Health for All into a narrow Specific Primary Care approach which has further destroyed the integrated model of the Bhore Committee.

It was the independent ICSSR/ICMR report 'Health for All: An Alternative Strategy in 1981' [7] which after reviewing health in its larger socio-political-economic dimension provided an alternative highly cost-effective model for health in which the people have to play the dominant role. This independent report clearly stated that this could not be achieved unless the people, and not mere elected representatives and bureaucracy controlled this model. All the non medical components of health and even 80% of all medical components viz. preventive, promotive as well as curative medical care can be best undertaken by the people themselves at the village level with their own local women provided with highly specific and practical training in the problems affecting the health of their community using all methods and systems of health and medical care. Also that over 95% of all problems including specialized medical and surgical care could be tackled within the 100,000 population block/taluka level. This report also clearly stated that this could be achieved only under Panchayati Raj where the people would

7. ICSSR/ICMR, **"Health for All: An alternative Strategy"**, Indian Institute of Education, Pune, 1981.

have both financial and administrative control over all functionaries and activities at their level. Only this could provide the dominant social and human component of health and medical care which is so lacking in the existing public and private sectors. Above all this would ensure accountability to the people without need for `targets' and transfers. This would also overcome the problems of unionization which plague the existing bureaucratic system and ensure that salaries would be in keeping with local rates. A many faceted improvement on the existing system. Such a decentralized people controlled system would ensure adequate manpower, infrastructural and medicinal requirements as would be determined by the needs of the local people than by a distant national and international bureaucracy with their own perceptions and interests. Like in the UK, such an effective People's Health System would also be the most appropriate means for controlling the otherwise unaccountable private sector.

The 73rd and 74th Constitutional Amendments empower people to undertake the 29 subjects affecting almost all aspects of their life, including health, at each level of the Panchayat system. The struggle for transfer of power and with it the resources is now an ongoing process which can be delayed but not reversed in what is now the true form of democracy of a face to face Participatory nature and not of a distant Representative type which has failed to deliver the goods. This is the democracy conceived by the founder fathers of our nation, an age-old practice suited to the 700,000 villages of our country. ■

2 Health Sector Changes and Health Equity in the 1990s in India

Aditi Iyer and Gita Sen

Introduction

Assessing the magnitude, direction, and impact of changes in the health sector in India during the 1990s is complex. Not only has there been a multiplicity of changes at both the micro and macro levels affecting aspects ranging from health financing to health-related behaviour, but the data are fragmentary and disparate in their reliability and scope. Analysts to date have therefore tended to address partial aspects and have often had to hypothesise rather than confirm. The data with the widest coverage are the two surveys of morbidity done by the National Sample Survey in the mid-1980s and 1990s, and the NCAER survey of household utilisation of health services and expenditures in the early 1990s. The report of the second NSS survey has only become available since 1998, and has not been much commented on as yet.

Our concern in this paper is to use some of the data from these surveys, together with the empirical results of other studies to put forward some preliminary results of significant changes that appear to have occurred in the 1990s, especially in relation to the question of health equity.

(involving both public and private sectors) vis-à-vis health needs, the lack of a unifying framework of financing and regulation, and a poorly developed referral system are some other important reasons why universal access to care has not been ensured. In consequence, health care is something of a privilege that only certain sections of the population have consistently managed to enjoy. This is ironic considering that the total quantum of health resources including human power and health institutions is quite large in aggregate terms (Jesani 1996).

The Rural-Urban Divide

Health services are grossly skewed in their distribution: urban areas and economically developed regions have attracted a larger share of health resources than warranted by their share in the total population, while economically backward and remote areas have remained consistently under-served in this regard. In 1991, the year that India began to liberalise its economy, a mere 32 per cent of all hospitals, 20 per cent of all hospital beds and no more than an estimated 41 per cent of all trained doctors were in rural areas where over 70 per cent of the population lived (Duggal et. al. 1995a).

The skewing of resources towards the urban areas is compounded by the fact that the paucity of doctors in rural areas is particularly evident in the case of allopathic doctors as opposed to those trained in the Indian Systems of Medicine and Homeopathy. Surveys in two districts of Maharashtra – Ahmednagar and Satara – with average general development indicators confirm this trend. Of all the practitioners who worked in economically backward areas of Satara district, trained allopaths and homeopaths constituted a minuscule 5 and 9 per cent respectively while practitioners of the Indian Systems of Medicine constituted 41 per cent. As against this, the proportion of unqualified practitioners was an enormous 45 per cent (Nandraj and Duggal 1997). In Ahmednagar district, about 71 per cent of all doctors were located in five developed talukas while the remaining 29 per cent were in eight underdeveloped talukas (Sule 1999). As a result, the average population-to-doctor ratios were 812:1 and 1806:1 in developed and underdeveloped talukas respectively. Specialists, mostly trained in allopathy, tended also to gravitate towards urban markets (ibid.).

Rural areas received a declining share of qualified practitioners between 1961 and 1981 even as medical education expanded, mainly in private colleges recognised by the Medical Councils (Jesani and Ananthraman 1993). This is because opportunities for employment in the public sector failed to keep pace with the increased out-turn of graduates. The irony is that rural posts remained unfilled even as graduates scrambled for the available jobs in the urban private sector, and therefore most graduates set up solo private practice mainly in urban markets.

The survey in Ahmednagar also shows that private health services tend to be clustered around places that are better provisioned with public health facilities and infrastructure (Sule 1999). As private health services are financed by out-of-pocket payments made by their users, the location of such facilities is determined by the presence of a market that can support them. Taken together, problems of access are thus real and serious for those who reside in rural, underdeveloped and/or remote areas.

But the extent of the rural disadvantage varies from one state to the other. States like Kerala, Punjab, Goa, Manipur and Mizoram, which have invested more in public rural health services, have been able to reduce the rural-urban chasm unlike states like Bihar, Jammu & Kashmir, Haryana, Rajasthan, Himachal Pradesh (Duggal et.al. 1995a).

On the whole, the government (central and state) while lamenting the problem of rural areas has done little to redress this maldistribution: it has not sought to reorganise its services through fiscal measures. While some state governments have attempted to make rural service a requirement for medical graduates or provided incentives for such service, there has been no uniform policy in this respect since health is a state subject.

The Private Versus Public Sectors

Private Health Sector

Compared to the public sector, the private sector, comprising the private-for-profit and the private-not-for-profit sub-sectors, is predominant in terms of its share of qualified practitioners[4] and institutions[5]. An estimated 85 to 93 per cent of all qualified doctors work here, largely as solo practitioners (Jesani and Ananthraman 1993, Sule 1999). According to official data, an estimated 65 per cent of all hospitals are privately owned. These are generally small institutions that taken together do not exceed an estimated 35 per cent of all hospital beds. A number of corporate hospitals were set up in the 1980s but these are not as numerous as the hugely disparate subset of nursing homes[6].

The picture with regard to the relative shares of the public and private sectors in utilisation rates was more mixed at the

4 Individual providers in the private health sector include qualified practitioners, who are registered with medical councils; those not fully qualified like licentiates or registered medical practitioners and those who may have no qualifications at all. The non-formal private sector includes the range of traditional healers including witchdoctors and traditional birth attendants (also known as *dais*), etc.

5 Private institutions range from large corporate hospitals to small 10 to 14 bedded nursing homes, polyclinics, dispensaries, radiological and diagnostic centres, blood banks and pathological laboratories.

6 Nursing homes are hugely disparate in their size, quality and in the range of services they provide. Most of them are owned by individual practitioners and are mostly situated in developed areas in rural and urban areas.

equipment (Sukanya 1996), much more than their expenditure on real estate or on building construction. Given that corporate hospitals work on the principle of cost recovery, it would be useful to know how many of the tests they recommend to their patients are essential or whether they are seen as principally a means of recovering their substantial investment.

"Cross practice" is rampant: few of the doctors trained in the Indian Systems of Medicine and Homeopathy practice their science to the exclusion of allopathy. District level surveys show that most non-allopathic doctors, especially those working in economically backward areas, actually practice allopathy either exclusively or in combination with their system of medicine. As many as 68 per cent of the ayurveds and homeopaths and 77 per cent of the unqualified healers practised mainly allopathy (Nandraj and Duggal 1997). This is because many of these practitioners who work where allopaths do not, are motivated to prescribe allopathic drugs to facilitate "quick" cures that will satisfy their clients (Sule 1999).

Unnecessary and irrational use of medicines – including indiscriminate use of injections and "drips" (intra-venous fluids), especially in rural areas and in poor urban communities – is one manifestation of the compulsion to effect instant cures. An analysis of 3582 prescriptions in Satara district of Maharashtra (Phadke et.al. 1995) showed that the proportion of rational prescriptions was as low as 18 per cent for all doctors covered; it was lower still for doctors in the private sector. Moreover, the proportion of undesirable and/or irrational drugs that were prescribed was quite high for all types of doctors but significantly higher among private doctors (ibid). The same study showed that as much as 69 per cent of the resulting expenditure was unnecessary. Another study of the anti-tuberculosis treatment regimens of 100 private practitioners unearthed a total of 80 different regimens, most of which were inappropriate and expensive (Uplekar and Shepard 1991).

Knowledge about the prices of drugs and, more importantly, their side effects is unreliable and variable among doctors, especially those in the private sector who receive their continuing education from medical representatives of pharmaceutical companies. Informal conversations by one of the authors of this paper with marketing personnel of pharmaceutical companies and medical representatives reveal that, as a strategy, they do not broach the subject of side effects or prices while selling their products to doctors. Such information is provided only if asked. They also tend to focus more on popular doctors especially

in cities. This makes knowledge about drugs and therapeutics uneven and lopsided.

Sale of drugs without prescriptions in private pharmacies is extremely common. Often, the people behind the counter recommend medicines on the basis of what appears to be popular and with no regard for possible side effects. This includes prescription antibiotics and contraceptives requiring counselling among others.

Many of the quality-related problems discussed above are obviously the result of an inadequate system of regulation of the private sector. As such, all consumers – both the poor and the better off – are potentially affected. But the poor, especially in a country like India where poverty, illiteracy, and gender and caste oppression go hand in hand, have fewer resources to circumvent these problems, or to challenge health practitioners or institutions on their own. Inequity thus gets locked in.

Public Health Services

Because health care is an essential need / commodity, the demand for services from the private health care sector can be highly inelastic in the absence of a functioning public health system as a base. What this means is that, unless people have an alternative, they would be willing to pay very high prices (and put up with poor quality), or be forced to opt out altogether. Such opting out means a burden of untreated morbidity and an often hidden cost in terms of women's time and labour as the health care providers of first and last resort in the home. A well-functioning public health system not only assures those at the lower ends of the social hierarchy with effective services, but can also set a ceiling for prices, and a norm for quality in the private sector. It can therefore be a major anchor for equity overall in the health service system. Some evidence in this regard exists for India (Krishnan 1995). Inter-state comparisons appear to point in this direction with states where the public health services are better showing lower prices in the private sector. However, the public health system itself leaves much to be desired in terms of quality and accessibility of services, and increasingly, of cost.

Unlike the private sector that has largely ducked rigorous planning and regulation, the public sector is centrally planned and has an elaborate system of Primary Health Centres (PHCs), sub-centres, Community Health Centres (CHCs), taluka and district hospitals in rural areas of most states. But they have also tended to be located in the more developed and accessible villages (ICMR 1991). Even within these 'catchment areas', operational problems – for example, inadequate transport or mismatch between the working hours of the PHC and the frequency of buses – limit the scope of access to a few villages/hamlets in the

immediate vicinity (ICMR 1988, Awasthi et. al. 1993). This is seen even in states that can claim to have achieved national norms of coverage[9] and distance[10] in aggregate terms.

Second, the referral system is poorly developed in most states. CHCs are inaccessible in part because there are too few of them[11] and due to their being poorly equipped. One of the major problems that they (as indeed PHCs) face is the one of attracting - and retaining - qualified practitioners with basic and specialist qualifications. At the end of 1992, for example, as many as 82 per cent of posts sanctioned for obstetricians and gynaecologists in Uttar Pradesh were lying vacant. Similarly, at the end of March 1993, some 68 per cent of all posts earmarked for paediatricians in Gujarat were unoccupied (GOI, DGHS, various years). The lack of trained medical staff in health centres has led to greater dependence on lower-level health workers - especially Auxiliary Nurse Midwives - who are socially vulnerable, ill-supported and unable to provide more than a selective and narrow range of services (Iyer and Jesani 1999).

Third, public financing of health care, which is mostly borne by state governments, has been inadequate and irrationally distributed. The share of health in the government's (combined Centre and states) revenue expenditure remained stagnant at 2.6 percent from the early 1950s to the mid-1990s (Duggal et.al. 1995 a & b). A major chunk of the expenditure goes towards hospitals and dispensaries, mainly in urban areas. Programmes directly funded by the Central government, such as the Family Welfare Programme, the National Disease Control Programmes and medical education are other major areas that show sizeable expenditures. Even these expenditures showed a proportionate declining trend since the 1980s and especially in the first half of the 1990s (ibid.) For instance, the persistently declining share (in total health expenditure on revenue account) in expenditures on public hospitals and dispensaries since the 1980s (Table 1) has coincided with an expanding pool of

9 PHCs and sub-centres are entrusted with populations of 30,000 and 5,000 respectively while CHCs are expected to cater to the needs of a 1,00,000-strong population. District hospitals in contrast do not have any clearly defined catchment areas. In 1992, 130,789 sub-centres were covering an average population of 4,795 while the 20,889 PHCs were catering to 30,022 people on an average. However, the establishment of CHCs was so woefully inadequate that the 2061 institutions that were already instituted in 1992 were dealing with three times the expected population load (GOI 1992).

10 Unlike population ratios, norms about distance and geographical coverage are achieved over time. All India data shows that the maximum radial distance covered by a CHC was 22.03km in 1992. PHCs covered 6.92 km. and sub-centres covered 2.76 km (GOI 1992).

11 CHCs are ideally expected to play the role of a first referral unit for four PHCs. Instead, at the end of 1992, the ratio of PHCs to CHCs was 10:1 (GOI 1992). In states like Uttar Pradesh, this number was as high as 15 while in Tamil Nadu this was an even higher figure of 20.

private hospitals that have received all manner of state support. This has steadily eroded the credibility of public hospitals. Questions of allocative efficiency become important too in the context of public health financing as a major portion of the available funds are absorbed by salaries.

Table 1: Expenditure on Hospitals & Dispensaries as Percentage of Total Health Expenditure

	1950-51	1960-61	1970-71	1980-81	1991-92	1992-93	1993-94 RE	1994-95 BE
States								
Andhra Pradesh		56.2	47.2	46.9	31.7	32.0	34.7	31.3
Assam	39.1	34.6	34.1	58.3	28.4	24.5	15.8	9.2
Bihar	27.5	30.3	30.3	51.9	NA	15.1	13.1	12.8
Gujarat		48.6	22.7	36.3	26.9	29.3	26.6	26.5
Haryana			28.8	27.0	20.2	19.9	19.2	18.0
Karnataka	63.0	44.9	30.9	43.2	24.3	20.9	24.3	22.9
Kerala		55.6	58.3	54.3	39.1	42.2	44.6	42.1
Madhya Pradesh	44.9	45.0	29.7	44.7	28.5	28.6	24.3	25.2
Maharashtra	41.4	38.5	28.9	28.3	25.3	26.6	28.1	26.2
Orissa	41.8	43.1	31.7	45.7	25.3	24.6	21.9	24.2
Punjab	51.9	44.8	35.6	51.9	23.2	35.4	30.7	30.6
Rajasthan		58.4	38.4	42.4	28.1	27.6	27.4	25.1
Tamil Nadu	65.2	54.2	43.2	62.5	36.4	35.9	43.4	43.5
Uttar Pradesh	52.4	35.2	37.1	39.4	28.7	30.1	32.3	32.3
West Bengal	27.6	20.6	36.7	48.3	37.9	38.9	36.3	37.2
All India	44.0	39.7	37.3	43.3	26.8	27.7	27.5	25.8

Source: Comptroller & Auditor General of India data (upto 1985-86) & "Demand for Grants" data for the states as analysed & presented by Duggal et.al. (1995a & b), Table 7: p. 843 & Table 10: p.904.

Notes:
RE - Revised Estimates
BE - Budget Estimates
NA - Not Available

These irrationalities and inadequacies result in acute shortfalls in the provisioning of even the most essential drugs and equipment in public health institutions, particularly in rural areas. A district level study of drug supply in Satara district of Maharashtra state showed that in public health facilities, not even one drug was available throughout the year: a minuscule 3 per cent of the required drugs were available for 90 per cent of the year (Phadke et. al. 1995). Inadequacies in the provisioning of equipment required to conduct even the most routine activities at PHCs and sub-centres, on the other hand, was brought out by a multi-centric study (ICMR 1991). Not only that, the few resources sent to the PHC for distribution to sub-centres, sometimes tended to get used up at the PHC itself while the sub-centres were left with virtually nothing (ICMR 1988).

Fourth, and importantly, a highly centralised mode of planning constrains the public health sector as it does other key public services such as education, and has resulted in programmes and services being insensitive to the needs and social realities on the ground. India was committed to comprehensive health care at Independence, and to Primary Health Care following the Alma Ata Declaration. In practice, the only road that it took was in the direction of *selective* primary health care consisting of a few disease control programmes and a Family Planning Programme, which for years, was the only health care to which women were "entitled". In fact, from the late 1960s, the focus on contraceptive method-specific targets in the family planning programme led to significant distortions in the delivery of health services through the public system. Workers at the periphery of the rural public health system, under the burdening influence of family planning targets, provided few other preventive services, let alone curative care (Sen et.al. 1998, Barge and Ramachandar 1999). Moreover, their competence also tended to get severely compromised by inadequate essential supplies and equipment, and selectively reinforced knowledge during the course of on-the-job supervision (Bhatia 1999, Iyer and Jesani 1999). Thus, for years, the public sector was associated with only selected preventive services while people used private services for curative care.

Despite the inter-state variation in quality and cost evidenced in the Krishnan (1995) study, it is difficult to avoid the conclusion that, in very large parts of the country, public health services have belied their potential to be a significant, less expensive, or accessible alternative to the private sector for the poor. In a sense, this was well-known by the end of the 1980s and the start of the 1990s when the liberalisation reforms began. The public debate on the direction of the health service sector has pitted those in favour of strengthening the public sector and more effectively regulating the private sector,

versus those who argue that privatisation is the route to follow. The latter argue that the record of public health services has been poor and the bulk of spending is in the private sector already. The actual direction of changes in the 1990s has favoured the latter.[12]

Health Equity in the 1980s and 1990s

In this section, we discuss health equity in the context of changes that have occurred in the health sector since the 1980s and especially in the 1990s. Although 1991 is typically bracketed as the year in which India formally launched reforms aimed at greater deregulation, liberalisation and privatisation, the health sector had already begun to move in this direction from the 1980s. During the 1990s, though, the impetus for these changes grew.

Privatisation

The progressive deregulation of price control over drugs under severe pressure from the pharmaceutical industry throughout the 1980s gained new legitimacy and greater impetus during the 1990s (Bidwai 1995, Rane 1998, Srinivasan 1999). The first Drug Price Control Order was passed in 1963 but never really implemented until 1970 when another order was legislated (Bidwai 1995). Following the Hathi Committee report in 1975 which was accepted by the government in power, Orders were passed in 1978, 1979 and 1987. Each of these orders liberalised the terms of price control in terms of the import-, retention-, and maximum sale prices of bulk drugs, the retail- and ceiling prices of scheduled formulations and the post-tax return on net worth (for bulk drugs). After 1980, the number of drugs under the purview of legislation was progressively brought down. In 1978, 347 drugs were included. This was brought down to 163 in 1987 and then to 76 in 1995 (Rane 1998, Srinivasan 1999, Bidwai 1995).

State support for privatisation, which began in the late 1970s and 1980s has not been limited to declining regulation of the pharmaceutical industry but grew in other ways as well, with public-private co-operation in health care delivery beginning to take on various modes (Gill 1996, Gill et.al. 1997, Purohit and Mohan 1996, Bhatia and Mills 1997, Bennett and Muraleedharan 2000). While their impact on equity has not been assessed adequately, the formal linkages that have been – or are being – attempted are many. They include the following measures.

12 Following 1994, the attempt to transform the existing Family Welfare Programme through the Reproductive and Child Health Programme and a target-free approach in family planning may be seen as a move towards strengthening public health services, but its results have been mixed to date (Sen et.al. 1998).

1. Orienting and training private practitioners for rational management of priority health problems like tuberculosis, acute respiratory infections, diarrhoea, etc. and in national programmes like the National Immunisation Programme, the Revised National Tuberculosis Programme, the Reproductive and Child Health Programme, etc.

   - The qualifications of these practitioners as well as their prescribing practices, charges for treatment, and the role of government services in the area would be important issues related to the quality of care and to health services equity more generally.

2. Transferring government facilities to private voluntary organisations and private parties. This includes transferring the running of government health centres in rural areas to private-not-for profit organisations. Now, the transfer of government hospitals in urban areas to private parties is also taking place although we do not have data on the extent to which this has happened.

   - While such transfers can indeed improve health services in the designated area, they do not rationalise existing resources. In some instances they do not solve the problem of access in remote areas, as both private for-profit and not-for-profit organisations often tend to be situated in developed states and districts. Also, achievements are difficult to upscale or replicate since, among other reasons, the tendency within the government system is to marginalise and ignore the potential learning from so-called 'pilot' initiatives.

3. Enlisting the help of retail outlets and private practitioners for marketing contraceptives.

   - Questions about whether information about contra-indications and side effects is provided would be important to answer.

4. Franchising treatment protocols to private not-for-profit organisations or to private enterprise. For example, franchising of the syndromic approach for treating sexually transmitted diseases to voluntary organisations situated along major highways in what is known as "The Truckers' Project".

   - The feasibility of universal application of treatment protocols in widely differing situations, remains a question. The need for flexibility would appear to be necessary.

5. Contracting the services of private specialists and hospitals for first referral services. Examples of this abound in the Reproductive and Child Health Programme as several states (like Rajasthan, Punjab, Uttar Pradesh, etc.) have been hiring the services of women gynaecologists to hold regular clinics in government health centres. Contracting the services of private companies for non-medical essential services (like laundry, equipment maintenance, catering) in government hospitals have taken place too.

   - The standards of care and the standardisation of charges must be addressed as also the question of accountability to government facilities.

6. Setting up autonomous societies to facilitate easier disbursement of funds and to operationalise programmes like the AIDS Control, Blindness Control and Reproductive and Child Health Programmes on the ground.

   - Co-ordination of the activities of these organisations with the bureaucracy, the quality of leadership and issues of political interference would crucially affect the success of this scheme. Equally important, is the question of financial and programmatic accountability of these bodies to the bureaucracy and to people.

7. Bringing public facilities under a corporate umbrella. This was evidenced when the Punjab Health Systems Corporation, which brought 150 public hospitals under its purview, was set up. It aimed to upgrade secondary health care with World Bank assistance, to introduce monetary incentives as a means to motivate the staff and to ensure the levy of service charges.

   - To what extent can corporations succeed in tackling the bureaucratic, operational and financial barriers to care is a question that needs to be asked.

It is clear that many of the above attempts at co-operation between public and private health service provision are innovative and have the potential for seeding improved quality and access. However, we have also raised the large number of unanswered questions that must be addressed. Close monitoring of the effects of these changes is essential if their impact on health equity is to be effectively assessed.

The 1990s have also witnessed various attempts at broadening health-financing options. The proposal to introduce user fees for laboratory services, use of the ambulance and on registration to

secondary and tertiary hospitals in rural and urban areas is one example, even though it has not been consistently implemented. Various modes of community financing have been tried too – for example, panchayats in Kerala controlling and managing the finances and administration of government health services (Rao et.al. 1995). Finally, the opening up of the insurance sector to private and foreign companies is a more recent development amidst much political opposition and concern about health equity and costs.

Equity Concerns: Access, Utilisation and Costs of Care

The previous section's discussion on trends towards greater privatisation provides the backdrop for this section's examination of trends in health care access, utilisation and costs based on national survey data. To assess the trends in utilisation and costs from the mid-1980s to the mid-1990s, we have compared the results of two surveys of the National Sample Survey Organisation: the 42nd and the 52nd Rounds, covering 1986-87 and 1995-96 respectively, on morbidity and utilisation of health services (NSSO 1992, 1998). We have disaggregated all-India data by economic status[13], gender and rural or urban location to the extent possible. In an earlier draft of the paper, we attempted to interpolate data from another national survey by the National Council for Applied Economic Research (NCAER) that was conducted during 1993 (Sundar 1995). However, there are such significant differences in methodology between the NCAER and NSS surveys, that direct comparison of the data is meaningless. These include differences in the choice of households, mode of data collection, in recall periods and in the definition of concepts of illness and care (as detailed in Appendix 1). As a result the NCAER data would tend to show comparatively greater levels of morbidity, higher rates of treatment, especially among women, and higher expenditure on outpatient care but not on hospital care.

The methodology of the 42nd round NSS survey (1986-87) has been commented on by authors like Vaidyanathan (1995) and Gumber and Berman (1995). In particular, the morbidity data appear to be beset not only by the usual problems of self-reported morbidity but also to have systematically underestimated illness and possibly the costs of hospital care. Smaller studies such as that by Madhiwalla et. al. (2000)

13 We have considered monthly per capita expenditure (MPCE) fractiles as calculated by these surveys as proxy indicators of economic status. However, the trend analysis is likely to be affected by the differing methods by which these fractiles were computed. The 42nd Round, for instance, computed them on the basis of responses to one question. The 52nd Round, in contrast, considered responses to a series of detailed questions. This is why the 1986-87 data may not be "discriminating enough to be a good proxy for the level of living of the households" (NSSO 1998: 20-21).

suggest much higher rates of morbidity than the NSS surveys. Gender biases may also be significant. It is not clear therefore how reliable or useful the morbidity comparisons really are. Nonetheless they raise some issues regarding methodology that are worth noting.

Reported Morbidity as a Reflection of the Need for Care

Access to health services is a many-layered problem. At its core lies a health concern whose recognition results in a medically indicated and/or perceived "need" for care. Next comes its social legitimisation in the household – in other words, its affirmation and the endorsement of health-seeking behaviour. At a third level lie questions of the availability and affordability of care.

In a society undergoing wide ranging reforms that affect the ground realities that people confront, health care access is likely to be affected in a number of ways. First, the quantum of the "need" for care could change and with it, the demand for care. Second, the terms under which health care can be availed of and the costs that must be incurred may change. However, cultural practices and the status of different individuals within households, which are slower to change, would continue to mediate the recognition of need, and also the accessing of care even when need is recognised.

People's need for care, as manifested in reported morbidity, is determined by a host of socio-economic and environmental factors. Among them, people's (especially women's) work burdens, adequacy of rest and nutrition, living and working environments (including water supply, sanitation, hygiene, ventilation, exposure to pollutants and hazardous chemicals, etc.) are important. District level studies vividly illustrate the relationship between reported morbidity and socio-economic indicators (Duggal and Amin 1987, George et.al. 1997, Madhiwalla and Jesani 1997):

- Reported morbidity rates are often positively associated with socio-economic status. Does this imply that the rich are sicker, or that the poor report less morbidity, not because they are healthier, but because they cannot afford to acknowledge or dwell on their ill-health?

- Sickness among women is linked to their social status in the family and to its implications for the sexual division of labour, and their access to rest and food. Rates are highest during the reproductive age when childbearing, child rearing and daily reproductive work impose huge work burdens, and when women are not old or senior enough to command better status. Rates increase further when they additionally engage in productive work. However, reported morbidity among women may be significantly biased downward because they themselves do not

know or cannot acknowledge it, or because of biases on the part of informants or survey enumerators.

- Morbidity is also a product of the environment in which people live. Rates of reported morbidity are higher in overcrowded and unhygienic urban slums than in neighbourhoods where better housing exists.

Morbidity is also functionally linked to the methodologies that studies employ. In Table 2, the fact that morbidity rates are consistently lower in NSS data compared to other national and district studies becomes evident. The 1993 NCAER study (Sundar 1995) and the district study (Madhiwalla et. al. 2000) presented show higher rates of morbidity for both males and females, in rural and urban areas.

Table 2: Morbidity Rates in National and Regional Surveys				*number ailing per 1000*
Ratio	**All India Surveys**			**Maharashtra**
	NSS	NSS	NCAER	(Nashik District)
	1986-87[a]	1995-96[b]	1993[c]	1996[d]
Urban				
Male30	79	98	286	
Female	33	88	108	310
Total	31	83	103	298
Female/Male				
Ratio	1.10	1.11	1.10	1.08
Rural				
Male64	83	106	347	
Female	63	87	108	381
Total	64	85	107	364
Female/Male	0.98	1.05	1.02	1.10
Ratio				
Sources: [a] NSSO (1992); [b] NSSO (1998); [c] Sundar (1995); [d] Madhiwalla et.al. (2000)				

The reporting of female morbidity is particularly sensitive to study methodologies and techniques of data collection. In contrast to the NSS, the district study presented in the table, incorporated gender perspectives in its methodology and analysis of data (Madhiwalla et.al. 2000). It demonstrates

that the full extent of women's morbidity becomes evident only when women are addressed one-to-one by women researchers after initial rapport building. It cannot be done through "intermediaries" as in the NSSO studies. Moreover, women, through long years of socialisation, often do not acknowledge health problems as such unless they are compelled to stop working. Chronic backache and persistent weakness are but two examples from a long list that also includes reproductive tract infections, etc. To elicit these subterranean ailments it is necessary to ask probing questions after an initial round of questioning. The Madhiwalla et.al. study showed that after such probing, the reporting of morbidity went up by 124 per cent (ibid.). Therefore, the rates of female morbidity, as elicited in the NSSO surveys, are probably gross under-estimates of the full extent of women's illness.

Trends in Reported Morbidity: 1986 to 1996

The 1995-96 morbidity rates shown in Table 2 are estimates by the NSS. Since the 1995-96 recall period for morbidity was 15 days, in order to make this comparable with the 30 day recall data of the 1985-86 survey, the NSS used the following: $NSS^{1995\text{-}96}$ *(30 days)* = $NSS^{1995\text{-}96}$ *(15 days)* + *PPC (15 days)*; where PPC is the number of persons reporting commencement of any ailment (acute and non-acute) during the 15 day recall period. We obtained morbidity rates for fractile groups using a similar method with one difference – we did not have access to PPCs of non-acute ailments and so our estimates count only acute ailments and would therefore be lower. These data are presented in Table 3.

The 1995-96 data show a definite association between morbidity rates and MPCE fractiles for both males and females, in urban and rural areas. The rates in the top fractile were 1.5 to two times *higher* than the rates in the lowest fractile in rural and urban areas. This marks a definite change from the mid-1980s when the relationship was an irregular one: reported morbidity increased incrementally as one moved from the bottom to the top fractile groups. This is a startling result which flies in the face of most micro surveys. The Madhiwalla et. al. study for instance found that morbidity rates were consistently higher among disadvantaged groups of women: migrants, scheduled castes and minorities in rural areas and among the poorest in urban areas. Furthermore, there appears no particular reason to believe that the better off became consistently more sick than those below them in the economic ladder during the 1980s and 1990s. While this needs to be explored further, it may well be the case that the underreporting of morbidity in the NSS data is disproportionately biased against the poor and women particularly rural women.

Table 3: Morbidity Rates: All India Trends						*number ailing per 1000*
	Male			Female		
	Rate		Change	Rate		Change
	1986-87	1995-96*	1986-96	1986-87	1995-96*	1986-96
Location						
Rural	64	83	30%	63	87	38%
Urban	30	79	163%	33	88	167%
R/U Ratio[$]	2.13	1.05		1.91	0.99	
MPCE Fractiles[@]						
Rural						
00 to 10	65	69	6%	65	64	-2%
10 to 20	56	63	13%	52	62	19%
20 to 40	67	71	6%	63	77	22%
40 to 60	54	79	46%	55	86	56%
60 to 80	67	85	27%	70	94	34%
80 to 90	78	100	28%	85	109	28%
90 to 100	62	122	97%	62	128	106%
Urban						
00 to 10	27	68	152%	30	64	113%
10 to 20	25	69	176%	31	75	142%
20 to 40	28	75	168%	28	86	207%
40 to 60	27	78	189%	33	85	158%
60 to 80	43	79	84%	47	97	106%
80 to 90	24	86	258%	28	110	293%
90 to 100	21	102	386%	33	99	200%

Source: 1985-86 (NSSO 1992, Statement 10, p.65)
1995-96 (NSSO 1998, Source Tables: 1.2 & 9.2, p. A-21, A-53, A-126, A-158).

Notes: * The morbidity rates for 1995-96 (with a 30 day recall period) are estimates by the NSS (NSSO 1998: 18-19). $NSS^{1995\text{-}96}$ (30 days) = $NSS^{1995\text{-}96}$ (15 days) + PPC (15 days) where PPC is the number of persons reporting *any* ailment (acute or non acute) during the 15 day recall period. Calculated ratios in the table are slightly lower than the NSS estimates because of non-availability of PPC for non-acute ailments.

[$] R/U Ratio refers to the Rural to Urban Ratio

[@] Monthly Per Capita Expenditure (MPCE) Fractiles are rough proxy indicators of economic status

Rates of reported morbidity were higher in 1995-96 especially for the uppet 60% fractile groups, for both genders, in rural and urban areas (Table 3). The 1985-86 rate of 31 per 1000 for urban areas shot up by 168 per cent. In contrast, the rate of increase of rural morbidity was 33 per cent. The greatest increases in morbidity reporting were in the top-20 fractile groups. The rates of increase were marginally higher among females than males (38 as against 30 per cent in rural areas, 167 as against 163 per cent in urban areas). These fractile differences in the increases in morbidity lend further credence to our earlier concern that the data for the poor may be biased downward.

Given the concerns regarding the underestimation of morbidity in the NSS surveys compounded by possible biases against recording the illnesses of the poor and women, it is not possible to draw significant conclusions from the data. One obvious suggestion is that the NSS needs to ensure that such biases are corrected in any future survey if the information is to be more useful.

Patterns of Health Care Utilisation

How have utilisation patterns been affected by reforms in the health sector? It is a difficult question because the NSS surveys present data that are not easily comparable. (One presents the data as rates, the other does so in per 1000 distributions, one provides gender disaggregated data, the other does not). Given this difficulty, we have only been able to look at aggregate data on the utilisation of the public and private sectors in rural and urban areas.

Subject to our earlier caveats about underestimates in the NSS data on morbidity among poor and women, the data on utilisation suggest that as many as 91 per cent of the patients with ailments in urban areas and 83 per cent of those in rural areas sought treatment[14]. There also appeared to be a marginal increase in the proportion of patients seeking treatment in 1995-96 compared to 1986-87. In states like Punjab and Haryana, moreover, the proportion of treatment seeking was nearly 100 per cent in rural and urban areas. Treatment seeking was poorly indicated in only two states, Orissa and in Assam. However, these data are for the aggregate and do not tell us whether there were significant differences in utilisation by socio economic class and gender. Later in the paper, we will examine such differences in the context of untreated morbidity.

14 The NSS surveys have succeeded in reflecting only formal sources of medical care. They consider only the treatment that is obtained from doctors but discount the care that people - especially women - might seek and/or provide; namely, home remedies, self-medication, faith or religious healers and other informal care. So the data actually underestimates the full extent to which people seek formal and non-formal "medical" care. In the case of hospitalisation, the survey does not include deliveries in their definition of in-patient care.

At the same time, the rates of hospitalisation showed a clear decline in rural areas (from 28 to 13 per 1000 persons in 1995-96) even as urban areas showed a slight increase (from 17 to 20 per 1000 persons in 1995-96). The extent to which hospitals are used is linked to the costs of care and the costs of *accessing* care (a figure that would be higher in rural areas). This is why the rates of hospitalisation dipped by 825 per cent in the lowest fractile compared to the upper fractile in rural areas. This could also be a reason why the rates were lower in poorer states like Bihar, Assam, Madhya Pradesh, Rajasthan and Uttar Pradesh.

Table 4: Utilisation of Out-Patient Care: All India Trends				*Per cent distribution*
	Rural		Urban	
Health Sectors	1986-87	1995-96[$]	1986-87	1995-96
Share of Public Sector	**25.6**	**19.0**	**27.2**	**19.0**
Public hospital	17.7	11.0	22.6	15.0
PHC/CHC*	4.9	6.0	1.2	1.0
Public dispensary	2.6	2.0	1.8	2.0
ESI doctor	0.4	0.0	1.6	1.0
ANM/MPW/AWW[@]				
Share of Private Sector	**74.5**	**80.0**	**72.9**	**81.0**
Private hospital	15.2	12.0	16.2	16.0
Nursing Home	0.8	3.0	1.2	2.0
Charitable Institution	0.4	0.0	0.8	1.0
Private doctor	53.0	55.0	51.8	55.0
Others[#]	5.2	10.0	2.9	7.0
Total	100.1	99.0	100.0	100.0

Sources: 1986-87 (NSSO 1992, Statements 13R & 13U, p.67-68) 1995-96 (NSSO 1998, Table 4.10, p. 22)

Notes: [$] Estimates based on those treatments with reported source of treatment.

PHC - Primary Health Centre, CHC - Community Health Centre

[@] ANM - Auxiliary Nurse Midwife, MPW - Multipurpose Worker
AWW - Anganwadi Worker

Among those who sought non-hospital care in 1995-96, as many as 80 per cent did so in the private sector. 55 per cent consulted private practitioners and a smaller proportion of 12 and 16 per cent approached private hospitals in rural and urban areas respectively (Table 4). Already in 1985-87 the private sector dominated the delivery of non-hospital care at an aggregate level (NSSO 1992). The additional increase in the share of the private sector during the decade under consideration (from 74.5 to 80 per cent in rural areas, and from 72.9 to 81 per cent in urban areas) further strengthened the pre-existing trends. What is also striking is the fall in public sector utilisation in poorer states like Rajasthan (46 to 36 per cent in rural areas and 52 to 41 per cent in urban areas), Assam, urban Orissa, and urban Madhya Pradesh (Table 5).

Table 5: Public Sector Utilisation for Out-Patient Care: States

				per cent of total outpatient
	Rural		**Urban**	
	1986-87	1995-96	1986-87	1995-96
States				
Andhra Pradesh	12	22	16	19
Assam	40	29	26	22
Bihar	14	13	17	33
Gujarat	28	25	18	22
Haryana	15	13	19	11
Karnataka	32	26	30	17
Kerala	32	28	33	28
Madhya Pradesh	24	23	28	19
Maharashtra	21	16	15	17
Orissa	37	38	43	34
Punjab	12	7	11	6
Rajasthan	46	36	52	41
Tamil Nadu	28	25	31	28
Uttar Pradesh	NA	8	14	9
West Bengal	16	15	20	19
All India	**21**	**19**	**24**	**20**

Sources: 1986-87; 1995-96 (NSSO 1998, Table 4.12, p.25)

The increase in the private sector and the decline in the public sector are not uniform however across sub-categories within these two broad classifications. In the rural areas the share of both public and private hospitals declined while the share of PHC/ CHCs (in the public sector) and of nursing homes, private doctors, and "others" (including medical shops, faith /religious healers and others) in the private sector increased. To the extent that lower level institutions such as PHCs and CHCs are picking up some of the patients who earlier would have gone to a hospital, this may be a trend in the direction of greater efficiency of use of public sector institutions. However the equity implications of the overall trend towards greater use of the private sector must be investigated further.

While the private sector was already predominant as regards outpatient care at the start of the period, this was not true for inpatient care where public hospitals accounted for about 60 percent in the mid-1980s. This has now changed. The share of the private sector overall in hospitalisations went up significantly during the period. Among those who were hospitalised in 1995-96, 55 and 57 per cent went to private sector institutions in rural and urban areas respectively compared to 46 and 40 percent in 1986-87 (Table 6). The share of public hospitals fell sharply in both rural and urban areas, while that of private hospitals increased. The use of PHCs remained at the same level. The use of private nursing homes went up in rural and urban areas while the use of in-patient facilities run by charitable institutions went up in rural areas but fell in urban areas.

Table 6: Utilisation of Hospital Care: All India Trends				*per cent of distribution*
	Rural		*Urban*	
Health Sectors	1986-87	1995-96	1986-87	1995-96
Share of Public Sector	**59.7**	**45.2**	**60.3**	**43.1**
Public hospital	55.4	39.9	59.5	41.8
PHC*	4.3	4.8	0.9	
Public dispensary		0.5		0.4
Share of Private Sector	**40.3**	**54.7**	**39.7**	**56.9**
Private hospital	32.0	41.9	29.6	41.0
Nursing Home	4.9	8.0	1.9	11.1
Charitable Institution	1.7	4.0	7.0	4.2
Others	1.7	0.8	1.2	0.6
Total	**100.0**	**99.9**	**100.0**	**100.0**

Sources: 1986-87 (NSSO 1992, Statement 2R & 2U, p.53-54)
1995-96 (NSSO 1998), Table 4,16, p. 28
Notes: * PHC - Primary Health Centre

These trends in hospital utilisation are significant because they reverse the situation that prevailed until the mid-1980s, namely, that of greater public sector use in hospital care (NSSO 1992). In fact, between 1986 and 1996, the rise of private hospitals and nursing homes went hand in hand with a general decline of public hospitals. This is a reflection of the falling investment in public hospitals and dispensaries – amidst emerging private hospitals – that we described earlier. While it may be argued that consumers are actually voting with their feet given the poor quality of services in public hospitals, (and there is undoubtedly some truth to this), at least some of this quality problem can be attributed to the reduced investments. Furthermore the problem of affordability of the services of private hospitals is a major issue for the poor, and hence a major equity-related concern.

Table 7: Public Sector Utilisation for In-Patient Care: 1995-96*

			number per 1000 in-patients
	Rural	**Urban**	**Expenditure on public hospitals/ dispensaries***
			1994-95 (BE)
States			
Andhra Pradesh	225	362	31.3
Assam	738	652	9.2
Bihar	247	346	12.8
Gujarat	321	369	26.5
Haryana	305	373	18.0
Karnataka	458	298	22.9
Kerala	401	384	42.1
Madhya Pradesh	533	560	25.2
Maharashtra	312	318	26.2
Orissa	906	810	24.2
Punjab	394	276	30.6
Rajasthan	649	731	25.1
Tamil Nadu	411	357	43.5
Uttar Pradesh	471	398	32.3
West Bengal	820	721	37.2
All India	**453**	**431**	**25.8**

Sources: 1995-96 (NSSO 1998, Table 4.17, p.29) 1994-95 (BE) ("Demand for Grants" data analysed and presented by Duggal et.al. 1995b, Table 10: p.904).
Notes: "Not reported" cases are excluded BE - Budget Estimate
* Expenditure calculated as percentage of total health expenditure.

While the all-India picture is one of declining utilisation of public hospitals, state level variations remain (Table 7). In Rajasthan, Orissa, West Bengal and Assam, the use of public hospital continued to be high. In general, the nature and quantum of private sector use has tended to vary in different states. In 1986-87, it was shown that states showing higher investment in the development of health facilities also showed better utilisation rates of public health institutions (NSSO 1987 quoted by Duggal 1998). This would reiterate our earlier point that lowering investment would result in lowering rates of utilisation of public institutions. It would also indicate that the use of private institutions is at least partly because of poor state support for public health facilities (Krishnan 1995).

In general, one variable to which the utilisation of the private sector is directly related to is the purchasing power of households (Duggal with Amin 1989, Sundar 1995, George et. al. 1997, NSSO 1998)[15]. Within households, moreover, more resources are harnessed for the care of male members even though women tend to suffer greater morbidity. National and state level studies show that significantly lower sums of money are spent on the treatment of women and girl children in the household for both hospital and non-hospital care (Das Gupta 1987, Sundar 1995, NSSO 1998, Batliwala et.al. 1998).

For women, considerations like affordability, time, work, distances to be travelled and faith in the abilities of the health provider determine their access to and utilisation of care (Gupte et. al. 1997, Shatrugna et. al. 1993, Sundar 1995). Nor are these considerations mutually exclusive. A group of rural women in a drought prone area of Maharashtra, for instance, spoke of distance and time in terms of the money they would have to pay (for transport) or lose (as wages) (Gupte et. al. 1997). Another study in Haryana showed that the presence of public health care facilities had a positive impact on women's utilisation of care (Rajeshwari 1996) because that entailed fewer demands on household resources. Viewed in this way, debilitated public health institutions may not only have a negative impact on utilisation by the poor but may also severely impact women's access to and utilisation of care. The latter may be particularly relevant in states where gender biases against women in the household are more severe. It is worth remembering that it is these very states where women's health status is worse and their need for services most acute. We will return to this point later.

Cost of Care

Costs that are incurred on the treatment of ailments comprise medical fees, the costs of drugs, diagnostic facilities, institutional care as well as the costs of travelling to the health facility. Opportunity cost in terms of wages lost ought also in principle to be included. In 1993, of all the out-of-pocket expenditure that households incurred on in-patient and outpatient care, 51 and 71 per cent respectively went towards medicines and fees (Sundar 1995). This was more or less true in all states despite differences in their use of public and private care. For

15 In future work we plan to test a multivariate model for the determinants of the private-public mix in hospital use since there appear to a number of factors at work – investment levels, the range of services, quality, and cost among possible others.

instance, in the case of expenditure on outpatient care, variations across states were moderate: in rural areas, this proportion ranged from 56 to 77 per cent; in urban areas, it varied from 67 to 84 per cent (ibid.).

Expenditures on care in the private sector were expectedly higher, especially for in-patient care. Ratios of private to public expenditure crudely capture the cost differential in these sectors[16]. For example, in 1995-96, the cost incurred by those who secured in-patient care in private health institutions was 2.07 times the cost incurred by those who went to public institutions in rural areas (Table 9). The corresponding differential in urban areas was 2.43. In contrast, persons seeking outpatient care in the private sector in rural areas spent 1.44 times the amount spent by those who used the public sector. And those doing so in urban areas spent only 1.2 times as much as those who used the private sector (Table 8). The differentials vis-à-vis outpatient care are clearly not as great as those vis-à-vis in-patient care. This small cost differential may be strongly linked to the predominance of the private sector in outpatient care especially at the start of the period.

Table 8: Average Total Expenditure on Out-Patient Care: All India			*Rs. per episode*
	Costs of Care	Change	
Health Sectors	1986-87	1995-96	1986-96
Rural			
Public Sector	73	129	77%
Private Sector	77	186	142%
Total	76	176	132%
Private:Public Ratio	1.05	1.44	
Urban			
Public Sector	74	166	124%
Private Sector	80	200	150%
Total	79	194	146%
Private:Public Ratio	1.08	1.20	
Urban:Rural Ratio@	1.04	1.10	

Source: 1986-87 (NSSO 1992, Source Table 11.00, p. S-516) 1995-96 (NSSO 1998, Table 4.19, p. 32)
Note: *Includes expenses on home remedies, fees to faith/religious healers, payment to medical shops.

@Measures the differential in total expenditure incurred in both sectors.

16 The ratio of private to public expenditure is only a crude indicator because it captures only aggregate differentials and is not correlated with the nature of morbidity or the duration of hospital stay.

Table 9: Average Total Expenditure on In-Patient Care : All India Trends			*Rs.per hospitalisation*
	Costs of Care		Change
Health Sectors	1986-87	1995-96	1986-96
Rural			
Public Sector	320	2080	549%
Public Hospital	NA	2245	NA
PHC/CHC	NA	740	NA
Public Dispensary	NA	1887	NA
Private Sector	733	4300	486%
Private Hospital	NA	4394	NA
Nursing Home	NA	4185	NA
Charitable Institution	NA	3808	NA
Other	NA	3015	NA
Total	597	3202	436%
Private:Public Ratio	2.29	2.07	
Urban			
Public Sector	385	2195	470%
Public Hospital	NA	2191	NA
PHC/CHC	NA	2461	NA
Public Dispensary	NA	1977	NA
Private Sector	1206	5344	343%
Private Hospital	NA	5524	NA
Nursing Home	NA	5749	NA
Charitable Institution	NA	3078	NA
Other	NA	1630	NA
Total	933	3921	320%
Private:Public Ratio	3.13	2.43	
Urban:Rural Ratio@	1.56	1.22	

Sources: 1986-87 (NSSO 1992, Statement 6, p. 59) 1995-96 (NSSO 1998, Table 4.21, p. 33)

Notes: *PHC - Primary Health Centre, CHC - Community Health Centre

NA - Not Available

@Measures the differential in total expenditure incurred in both sectors

There are opposing trends in the private - public cost ratio for outpatient and inpatient care. In 1986-87, private outpatient care was on average only 5 per cent more expensive in rural areas and 8 percent more in urban areas compared to 44 and 20 percent respectively in the mid-1990s. For inpatient care, in contrast, the private–public cost ratio actually fell from 2.29 to 2.07 in rural areas and from 3.13 to 2.43 in urban areas. While the costs of all care went up significantly during the period (discussed below), it is worth noting that the cost of private outpatient care and of public inpatient care went up in comparative terms. In a sense this is a kind of "double-whammy" for the poor since private outpatient care was not much more expensive than public care earlier, and public inpatient care used to be much less costly compared to private care.

Compared to the mid-1980s, the costs of both out-patient and in-patient care have risen steeply in rural and urban areas Between 1986-87 and 1995-96, the average cost of private outpatient care rose by 132 per cent in rural and 146 per cent in urban areas (Table 8). The rise was higher in the private sector as we have seen. In rural areas, costs went up by 142 per cent (as against 77 per cent in the public sector); in urban areas, costs escalated by 150 per cent (as against 124 per cent in the public sector). The urban-rural price differential rose from 1.04 in 1986-87 to 1.10 in 1995-96.

The trends in the costs of hospital care between 1986 and 1996 are more dramatic (Table 9). Average costs spiralled by 436 per cent in rural and by 320 per cent in urban areas. Second, the significantly larger quantum of the rise in rural areas has resulted in a narrowing urban-rural (expenditure) differential from 1.56 to 1.22. Third, spiralling costs of care were particularly evident in institutions in the public sector as we have already noted. In rural areas, the quantum of the rise was as much as 549 per cent, more than the rise of 470 per cent in urban areas.

Together with the declining importance of the public hospital due largely to declining public investment, a major contributor to rising costs of outpatient and in-patient care is the escalation in drug prices. An analysis of drug prices between 1980 and 1995 revealed a 197 per cent for all (778) drugs selected for study (Rane 1996). In as many as 60 per cent of these the rise was more than 100 per cent. The sharpest increases were evident in the prices of anti-cancer drugs, many of which are imported (336 per cent) and for those drugs which hold something of a monopoly. Several of the drugs that need to be taken for long periods of time, like those acting on the thyroid, showed phenomenal increases of over 500 per cent. Getting increasingly costly too were a host of "inessential" drugs and irrational combinations too like balms, anti-

diarrhoeals, anti-obesity drugs, laxatives, enzymes, food products, some nutritional additives, etc. (ibid.).

This trend has continued during the post-1995 period. The prices of individual drugs sometimes went up by 10 per cent in a single year (Rane 1999). These were mainly drugs to treat cardiac conditions or iron tablets, which were "over priced"[17] to begin with (ibid. Srinivasan 1999). The experience of rising prices of drugs itself is contoured not merely by the actual prices of drugs but by prescribing practices of private practitioners who provide most of the outpatient care[18].

Taken together, these enormous rises in the costs of all types of care impose heavy burdens on people, especially those with few means. Prabhu et al (1996) showed that the proportion of household spending on treatment by the poorest income groups in five major states rose sharply between 1961 and 1987 and was higher than the average health expenditure for all income groups. District surveys in Maharashtra and Madhya Pradesh during the late 1980s and early 1990s have shown that expenditure on health obtained largely from the private sector constitutes as much as 7 to 8 per cent of total consumption expenditure (Duggal with Amin 1989, George et. al. 1997). What is worse, this proportion has tended to rise among groups belonging to the lower socio-economic classes (ibid).

On the basis of these findings, one could hypothesise that the cost of accessing health care may have had any or all of the following impacts: cutbacks on other areas of social consumption like food which directly impacts on health status; increased indebtedness, especially among the poor; growing untreated morbidity, and growing gender and possibly age biases in health seeking behaviour. At least the first two of these outcomes were evidenced by a community-level study of the impact of structural adjustment on poor households in Rajasthan (ASTHA 1998). Costs and affordability also crucially determine women's access to care, especially in

17 Srinivasan (1999) compared the tender prices of drugs purchased by the Tamil Nadu Medical Services Corporation – the sole purchaser for the Tamil Nadu state government health institutions – with the market prices of equivalent formulations from the Monthly Index of Medical Specialities and worked out what he calls an "Over-Price Index".

18 Private practitioners receive most of their "continuing education" about drugs and therapeutics from medical representatives who do not provide information about side effects and costs unless specifically asked. Thus, older drugs that may be as effective and less inexpensive tend to be needlessly substituted by newer and more expensive drugs.

poorer groups. In the face of rising costs of care, it is likely that women may find it increasingly difficult to access formal care and may experience greater and recurring untreated morbidity.

Untreated Morbidity

As we saw earlier in the paper, the quality of the morbidity data in the NSS surveys leaves a lot to be desired. Both the overall rates and the rates for women are suspiciously low when compared to the results of community-level studies (Madhiwalla et. al. 2000), and also to the NCAER study which was more careful in attempting to rule out gender biases. Despite this caveat, the NSS data on untreated morbidity point to some trends that are in line with our expectations based on our findings regarding costs, and which bear further investigation.

Table 10: Rates of Untreated Ailments 1995-96: States

number untreated per 1000 ailing

	Rural			Urban		
	Male	Female	Total	Male	Female	Total
State						
Andhra Pradesh	231	281	255	128	172	150
Arunachal Pradesh	393	428	409	164	36	110
Assam	438	443	440	315	404	364
Bihar	214	224	219	158	152	155
Goa	6	1	3	177	82	133
Gujarat	53	106	79	42	29	35
Haryana	13	46	30	22	12	16
Himachal Pradesh	110	138	125	31	24	28
Jammu & Kashmir	53	73	63	32	14	24
Karnataka	161	276	223	104	68	86
Kerala	121	113	117	104	112	108
Madhya Pradesh	149	176	163	52	85	67
Maharashtra	96	132	114	78	76	77

Table 10: Rates of Untreated Ailments 1995-96: States (*Contd.*)						
State	**Rural**			**Urban**		
	Male	Female	Total	Male	Female	Total
Manipur	282	681	418	477	NA	697
Meghalaya	517	694	603	274	494	396
Mizoram	178	470	370	372	460	422
Nagaland	167	68	117	36	21	30
Orissa	307	339	323	157	114	134
Punjab	6	14	10	35	35	35
Rajasthan	140	49	102	94	115	104
Sikkim	209	164	187	70	16	35
Tamil Nadu	241	208	224	91	72	80
Tripura	355	512	434	236	275	256
Uttar Pradesh	87	101	94	53	74	65
West Bengal	206	192	199	90	112	101

Sources: 1995-96 (NSSO 1998, Source Tables 8.2, p. A-42-46, A-146-151)
Notes: * Untreated morbidity = 1000 (1995-96) minus rate of treated morbidity.

In 1995-96, 173 out of 1000 persons who reported morbidity in rural areas did not seek care. In urban areas, the corresponding rate was 93 (Table 11). Rates in the north-eastern states of Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram and Tripura as also Andhra Pradesh and Orissa were significantly higher (Table 10). More women reported untreated morbidity than men: 184 (as against 162) per 1000 in rural areas and 97 (as against 90) per 1000 in urban areas. However, these rates for women may be significant underestimates since the NSS surveys underestimate female morbidity and one can plausibly assume that morbidity that is not acknowledged or reported is even less likely to be treated within the formal system than that which is reported. In general, levels of non-utilisation by men and women proportionately declined when incomes in the house increased (NSSO 1998). This gradient may be steeper depending on the extent of underestimation of morbidity among the poor generally, and of untreated morbidity in particular, analogous to the argument made for women above.

Table 11: Rates of Untreated Ailments* : All India Trends								*number untreated per 1000 ailing*
	Rural			**Urban**			**Rural: Urban Ratio**	
	No.per 1000		Change	No.per 1000		Change	1986-87	1995-96
	1986-87	1995-96	1986-96	1986-87	1995-96	1986-96		
	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]
Gender								
Male	172.4	162	-6%	98.1	90	-8%	1.76	1.80
Female	198.0	184	-7%	118.9	97	-18%	1.67	1.90
Both	184.8	173	-6%	108.6	93	-14%	1.70	1.86
Female/								
Male Ratio	1.15	1.14	-1%	1.21	1.08	-11%		
MPCE								
Fractiles@								
Males								
00 to 10	198.2	276	39%	111.8	180	61%	1.77	1.53
10 to 20	175.6	210	20%	103.6	122	18%	1.70	1.72
20 to 40	192.5	175	-9%	103.1	91	-12%	1.87	1.92
40 to 60	172.8	170	-2%	88.6	80	-10%	1.95	2.13
60 to 80	167.9	162	-4%	91.8	72	-22%	1.83	2.25
80 to 90	141.7	132	-7%	92.5	38	-59%	1.53	3.47
90 to 100	103.6	85	-18%	122.6	102	-17%	0.85	0.83
Range	94.6	191.0		-10.8	78.0			
Females								
00 to 10	233.9	241	3%	190.5	193	1%	1.23	1.25
10 to 20	267.7	245	-8%	137.0	137	0%	1.95	1.79
20 to 40	198.1	217	10%	128.7	105	-18%	1.54	2.07
40 to 60	207.0	206	0%	126.4	95	-25%	1.64	2.17
60 to 80	194.7	177	-9%	71.4	82	15%	2.73	2.16
80 to 90	138.6	148	7%	90.0	54	-40%	1.54	2.74
90 to 100	92.8	106	14%	93.6	67	-28%	0.99	1.58
Range	141.2	135.0		96.9	126.0			

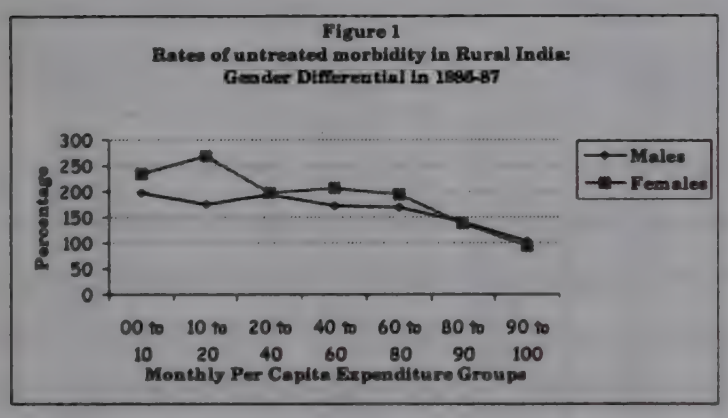
Source: 1986-87 (NSSO 1992, Statement 11, p.66) 1995-96 (NSSO 1998, Source Table 8.2, A-46, A-151).

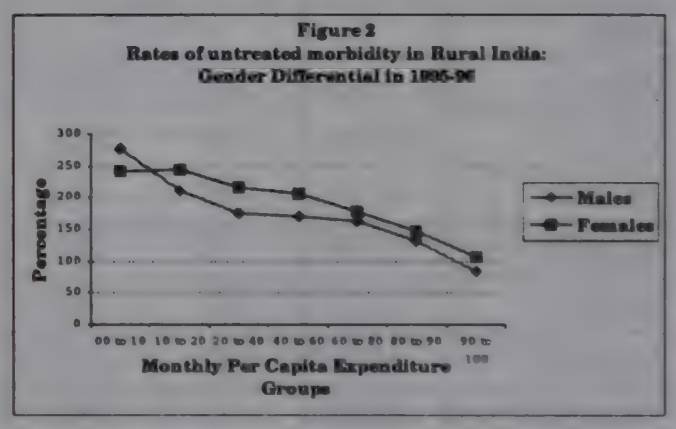
Notes: * Untreated morbidity = 100,000 (1986-87) or 1000 (1995-96) minus rate of treated morbidity.

@ Monthly Per Capita Expenditure (MPCE) Fractiles are rough proxy indicators of Economic status.

Compared to 1986-87, the overall rates of untreated morbidity appear to have reduced among men and women, in rural and urban areas. The gender differential also appears to have decreased, but given that the data may inadequately reflect the full extent of female morbidity, we believe that it does not reflect the full extent to which their ailments are left untreated[19]. On the other hand, the rural-urban differential has continued to grow as evidenced by rising rural vis-à-vis urban rates for both genders and across all fractile groups.

Despite the unexpected (and possibly data – induced) decline in untreated morbidity overall, a comparison of the difference in the rates of untreated morbidity between the uppermost and lowermost fractiles – the range, in other words – reveals a clear gradient in both rural and urban areas among men. This indicates worsening disparities between economic classes in the extent of untreated morbidity. For women, the differential came down a bit in rural areas, which would indicate lowering disparities, but it went up in urban areas Even so, the data indicates rising inequity across economic groups, especially in urban areas and among males.





The relationship between economic class and levels of untreated morbidity is captured when changes in the rates of untreated morbidity rates are computed in each fractile, in rural and urban areas, and separately for males and females. The rates of untreated morbidity among males showed substantial increases between 1986 and 1996 in the lowest fractile groups, especially in urban areas. In the lowermost fractile, the rates went up by as much as 39 and 61 per cent in rural and urban areas respectively. In the next lowest fractile, the rates of increase were to the extent of 20 and 18 per cent. The trend begins to get reversed in the middle fractiles and this gets heightened in the topmost group where rates actually fell by 17 to 18 per cent.

However, the trend is not so clearly indicated for women. There would appear

19 Smaller studies report significantly higher rates of untreated morbidity. They also show that non-treatment tends to be highest in the reproductive age. Women tend to leave untreated those conditions that are chronic but not incapacitating like reproductive problems, mental stress, weakness, aches and pains (Madhiwalla et.al. 2000, Shatrugna et. al. 1993, Bhatia and Cleland 1995, Bang et. al. 1989).

to be something of an increase in untreated morbidity in the lowest fractile group, but erratic changes that occur in the lower middle, middle and upper fractiles are probably the result of the data problems we have already discussed.

Table 12: Reasons for No Treatment: All India				*percentage*
	Rural		Urban	
	1986-87	1995-96	1986-87	1995-96
Reasons for no treatment				
No medical facility	3	9	0	1
No faith in medicine	2	4	2	5
Long waiting	0	1	1	1
Financial reasons	15	25	10	20
Illness not "serious"	75	51	81	59
Other reasons	5	10	6	12
Total	100	99	100	99
Source: NSSO 1998, p.21				

The survey does a better job of capturing male morbidity and utilisation of care – because men tend to seek formal health care more than women, and the reporting biases were probably greater for women. These data are able to show, unequivocally, that health care is becoming increasingly difficult for the poorer classes to access. This is borne out by the reasons that were offered for no treatment (Table 12). Compared to 1986-87, the proportion of those who were unable to access care because of "financial reasons" went up significantly in both rural and urban areas. So too did the recognition that there was no medical facility available. Correspondingly, the proportion of those who did not consider their health problems to be "serious" enough went down considerably.

Conclusion

The subject of health equity is a complex one with multiple determinants and various levels and dimensions. In this paper we have focussed on only one dimension, that of health services in the context of recent changes in health policy and the health system in India. No one would seriously argue that health services were equitable in the country prior to the decade of the 1990s. Despite attempts to develop a wide-ranging set of institutions and to provide a floor of basic services through the public system in order to meet the goals of affordable and accessible health care for all, the reality on the ground was rather different. Public health services were poor in terms of both access and quality. As a result, the bulk of health

expenditure was out-of-pocket, and a largely unregulated private sector in health was becoming increasingly dominant. Nevertheless, in those states where the scope and quality of public health services was better, the public sector did act to provide an important alternative especially for the poor.

Key changes during the last decade have however worked to erode health equity even further. The paper has focussed on three factors – the further deregulation of drug production and prices, the declining investment in public hospitals combined with growing subsidies to private corporate hospitals, and a range of other privatisation measures with mixed effects.

The paper shows, based on a comparison of the data of two NSS surveys done in the mid-1980s and 1990s, that

- the private sector (continuing unregulated) is now dominant in terms of both outpatient and inpatient services;

- the average cost of all treatment and especially of inpatient care has skyrocketed, linked to but not only because of steep increases in drug prices; and

- the extent of untreated morbidity (always higher among the poor) now shows a steeper gradient than before between those at the lower and upper ends of the economic spectrum.

Data on female morbidity in the NSS surveys are of doubtful quality, but we are able to draw some plausible inferences regarding the specific gendered impacts of the above trends. They suggest that gender inequity and economic inequity have probably gone hand in hand in the recent and currently ongoing trends in India's health services. ■

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Appendix 1

National Surveys on Morbidity, Utilisation and Expenditure on Health Care - A Comparison

	NSSO		NCAER
	42nd Round - 1986-87	52nd Round - 1995-96	1993
Scope	All states & U.T.s except Ladakh & Kargil districts of Jammu & Kashmir; rural areas of Nagaland All states & U.T.s except interior Nagaland;	Andaman & Nicobar islands; Ladakh, Kargil & Dodha districts of Jammu & Kashmir All states & U.T.s except Arunachal	Pradesh, Manipur, Mizoram, Nagaland, Sikkim, Tripura; Andaman & Nicobar islands; Dadra & Nagar Haveli; Lakshadweep; Jammu & Kashmir
Sample Size	12914 households: 8346 in rural and 4568 in urban areas	Analysis of central sample data only - 120,942 households: 71,284 in rural and 49,658 in urban areas.	18693 households - 6354 in rural and 12339 in urban areas
Sample Selection	Two stage stratified sampling procedure	Two stage tratified sampling procedure	Three stage sampling procedure
Mode of Data Collection	Interviews with detailed pre-coded questionnaire..... Report published in *Sarvekshana* does not provide details.	Interviews with detailed pre-coded questionnaire. Personal interviews with each adult male in household; information about adult females gathered through "intermediaries" in some cases. Information about children elicited through mothers.	Interviews with detailed pre-coded questionnaire. Names of all members listed down and details about each asked individually
Period of Data Collection	One year	One year	Two months (May-June)
Recall Period	365 days (hospitalised patients); 30 days (for non-hospitalised patients)	365 days (hospitalised patients); 15 days (for non-hospitalised patients)	30 days (hospitalised & non-hospitalised patients)

Appendix 1 *(Contd.)*

National Surveys on Morbidity, Utilisation and Expenditure on Health Care - A Comparison

	NSSO		NCAER
	42nd Round - 1986-87	52nd Round - 1995-96	1993
Definitions			
Monthly Per Capita Expenditure (MPCE) Fractiles	Based on responses to one question on average monthly household consumption expenditure during previous year.	Calculated from responses to a detailed series of questions	Fractiles not used in analysis. Survey uses other indicators of socio-economic status in the analysis
Utilisation of Health Care	Possibly includes only consultations with doctors. Report published in *Sarvekshana* does not provide details	Consultations with doctors only. Does not include self medication, home remedies or medical advice from non-medical persons.	Treatment in formal public & private sectors, medical shops, faith/ religious healers and others
Costs of Care	Report published in *Sarvekshana* does not provide details	Includes charges for bed, food, medicines, IV fluids, bandage, medical &/or paramedical services, diagnostic tests, operations, therapies, ambulance, oxygen, blood, etc. Social expenses not included	Includes charges for professional advice, medicines, clinical tests. Also includes expenses on special diet, rituals, transport, bribes, tips and incidentals

3 A Note on Equality and Equity in Access to Health Services: International and Indian Context

Debabar Banerji

The awesome concentration of economic, political and military power among the rich of the world has culminated in a very ludicrous and apparently untenable situation. A recent UNDP report says that countries which contain 20 per cent population of the world (including their own poor), consume as much as 86 per cent of the world's resources; among the remaining 80 per cent of the population 7 per cent of the resources are consumed by the upper 5-10 per cent of the rich, leaving the remaining 7 per cent to the 90-95% living in the poor countries. This untenable situation has perhaps impelled the rich to draw up their own facade of a 'pro-poor, pro-equality/equity' agenda. This ought to form the backdrop of any consideration of questions of equality and equity, globally as well as locally. Those who have genuine concern for the state of the poor ought to exercise utmost caution against being coopted by the rich in pursuing the interests of their own class.

The 1978 Declaration of Alma Ata, which, among other basic considerations, declared that health is a fundamental human right

and peoples of the world must be assisted to become self-reliant in coping with their health problems, marks a watershed in the history of public health. All the countries of the world, including the rich ones, signed it. However, the retribution for the poor for daring to claim self-reliance from the rich was swift and sharp. They launched what they called Selective Primary Health Care. Realising their financial dependence on the rich countries, the two sponsors of the Alma-Declaration, WHO and UNICEF, were quick to extend enthusiastic support for the patently untenable concept of SPHC. They also extended their enthusiastic support to the SPHC declarations at the Bellagio-I and II Conferences. It was a breathtaking demonstration of naked power by the rich to impose their will on the poor of the world; it will go down as one of the darkest chapters in the history of public health. This ought to be a major issue for discussion in the forthcoming World Health Assembly.

The rich, with full backing of international agencies unleashed a barrage of what are called 'international initiatives' on the peoples of the world - the very antithesis of the Alma Ata Declaration. UNICEF made a laughing stock of itself before the world by its abortive launch of programmes with acronyms, GOBI and GOBI-FFF and it did a great deal of quixotic saber rattling, threatening to unleash what it called Child Survival and Development Revolution. Nothing came out of these and UNICEF ended up in promoting a massive Universal Programme of Immunisation against six diseases without even determining some basic epidemiological data and the efficacy of the vaccines used at the time of inoculation in different countries of the world. Not to be left out, WHO followed up by supporting the unsupportable UPI and launched its own initiatives. Despite a great deal of fanfare, a number of them even failed to take off - Diarrhoeal Diseases Control Programme and the programme against Acute Respiratory Infections are glaring examples.

Apart from UIP, WHO had joined UNICEF/World Bank/IMF and many governmental and non-governmental international aid agencies to launch global operations for control/'elimination'/ eradication of AIDS, Tuberculosis, Poliomyelitis and Leprosy. One of the most astonishing features is that each one of these five displayed some common traits. Even though hundreds of millions of dollars were poured into each of the programmes, they conspicuously failed to conform to the most elementary norms of public health planning, programming, implementation and monitoring and evaluation: (a) they were ill-conceived; (b) they were very badly designed; (c) they were very poorly implemented, monitored and evaluated; (d) they were technocentric; (e) the same pattern was imposed on all the very widely diverse poor and dependent countries of the world; (f) no efforts were made to take

into account the social, cultural, psychological and political diversities of the countries; (g) they grievously damaged the rudimentary infrastructure of the health services by getting top priority to the implementation o the programmes initiated by them; (h) and, not surprisingly, each one of the programmes has failed to yield the results expected from them.

It is a profound irony that against the background of such a disastrous performance WHO should have coined the fashionable term, 'Evidence Based Medicine'. If it is really committed to evidence base, it ought to apologise to the poor countries for promoting programmes which lacked evidence concerning their key components, hold the persons concerned accountable and formulate alternate, evidence based programmes. Some examples:

a. The UIP was launched without having a reasonably reliable baseline, and therefore its impact on the problems could not even be measured. There were questions regarding the viability of the vaccines at the time of inoculation and reliability of the data churned out by government agencies;

b. Even if the fierce controversy concerning the etiology of AIDS is set aside, there are serious question marks concerning such aspects as its diagnosis, clinical features, natural history, comparative epidemiology, degree of infectivity and the course of the disease in different countries/ regions. WHO has not acquitted itself creditably either where it took over the responsibility of dealing with the problem in many parts of Sub-Saharan Africa. WHO/UNAIDS ought to be taken to task for making irresponsible forecasts concerning the disease in different parts of the world.

c. The Global Programme of Tuberculosis does not have even a baseline in terms of Annual Rate of Infection to measure its impact. In fact, the Pilot Studies carried out in India revealed that, despite all the inputs that cannot be replicated elsewhere in the country, it could cover only around 30 per cent of the expected case load in the population. The question of the programme making any epidemiological impact therefore does not arise. The extensive use of multiple drugs has led to a sharp rise in the prevalence of multi drug resistance in many parts of the world.

d. The much trumpeted Polio Eradication programme has failed to keep its deadline of eradication by the end of the century. There are, besides, still serious unsolved

questions concerning choice of the vaccine, its dosage and the daunting question of satisfactory coverage.

e. The saga of the Leprosy Eradication, which was later scaled down to 'Elimination', still continues mainly because of inadequate coverage.

Not unexpectedly, the vulnerability of all the programmes to scientific criticism has given a sinister cloak and dagger overtone to the programmes by their administrators. They have scrupulously 'ostracised' those who disagree with them and kept silent the most of the critiques that appeared in learned journals. Not collecting vital information, suppression of information, spreading of disinformation and misinformation have become a routine activity.

Vicente Navarro, Editor-in-chief of the ***International Journal of Health Services***, has used the term 'Intellectual Fascism' to describe his experiences of putting up with the witch hunt unleashed by Senator Joseph McCarthy in the US in the 1960s. Any deviation from the laid down line invoked punishment for indulging in 'Un-American Activities'. The imposition of the programmes on the poor countries, described in the foregoing, eminently qualified for practice of intellectual fascism. The oppressed peoples of the world have to undertake a new phase of anti-fascist struggle in order to get equality and equity (fair and just) in access to public health services.

The question of motivation for launching so many global programmes costing several billions of dollars is strong enough for us to be able to make some conjectures:

a. Finding market for its products, such as vaccines from the biotechnology industry, cold chain from the refrigeration industry and drugs and diagnostic kits for various diseases. Besides, though on a very modest scale, these programmes provide employment to many 'specialists' and other functionaries who can be trusted to carry on the agenda of the intellectual fascists.

b. Dealing with communicable diseases can make it 'safer' for businessmen to create markets in the poor countries, apart from saving enormous amounts in protecting the communities through routine vaccination. The then director-general of WHO, Halfdan Mahler had stated that by 'investing' US$ 600 million for smallpox eradication, the US alone had been saving one billion dollars annually by stopping routine vaccination against the disease in that country.

c. There is the possibility of increasing the dependence of the poor countries not simply for repayment of soft loans, but also to get the vital supplies needed for some of these programmes.

The International Monetary Fund has made its own contribution to intellectual fascism by forcing those governments which take loans from it to implement the 'Structural Adjustment Programmes'. These reforms included drastic cuts in the health budget all along the line, promotion of the private sector and enforcing cost recovery from state funded health organisations.

Confining himself to health issues, Ivan Illich had pointed out that more than three decades back the very nature of the exploitative interplay of market forces sharply skewed in favour of the affluent has created its own nemesis in the form of what he termed as 'medicalisation' of their lives. He has asserted that since then the sheer compulsions of the market has propelled them to lead to 'systematisation', where the medical establishment becomes a part of a larger, domineering system to the existing stage of 'conglomeretisation', involving the formation of massive industrial conglomerates consisting of numerous health associated elements - diagnostics, clinical activities and many other associated business ventures such as hospitals, insurance, accountancy, rehabilitation and 'healthy-living' industries.

Following the laws of capitalism, the rich exploitative classes in the poor countries have started to imitate the rich elsewhere by promoting expensive health related industries in their own countries. This has widened the inequality in the access to health services between the rich and the poor sections.

The activities of the unholy nexus between foreign agencies and national political and administrative leadership dealt a severe blow to the health service system of India. This is the third blow of such magnitude. Soon after India made a modest beginning by following the guidelines set by the Bhore Committee - for example, making available services free of cost, focus on the neglected rural population, importance to preventive services and creating what it called 'social physicians'. However, the Malaria Control/Eradication Programme was given top priority and as much as three-fourths of the already meagre rural health budget was siphoned off by it. After failing to fulfill the promise of eradicating malaria by 1964, the general health services suffered yet another severe neglect because of the top priority assigned to the family planning programme.

All the ill-conceived initiatives mentioned in the foregoing have devastated almost every component of the public health

service system. Bureaucrats, who do not have the necessary education and are 'birds of passage' in health ministries, dominate decision-making on technical issues. Physicians, who have little competence in the field, often occupy key public health positions in the country. This suits the foreign agencies as they are able to get their agendas accepted by uninformed people. There is a sharp decline in the quality of medical education and often it has become a commercial venture. The key institutions for education, training and research in public health and health administration have also undergone a steep decline.

This state of affairs got reflected in two surveys of utilisation of medical care in the country. It came up with the finding that 'next only to dowry, expenses incurred in getting medical care services is the most important cause of rural indebtedness'.

Remedies suggested may appear to be deceptively simple or simplistic. For instance, decentralization of health services through panchayats and nagar palikas has the very serious problem of overcoming the very powerful power structure which is deeply rooted in class and caste. Two major factors are key to entrusting "people's health in people's hands". One is the political courage to overcome the vested interests. The second will to have high degree of competence in health systems research to give shape to the entire structure of an alternative health services, starting from the grassroots. The degree of empowerment of people at the three levels of panchayats, and nagarpalikas of various sizes, the network of referral systems, cadre structure and its development and control, education and training of different categories of workers, are some of the issues that will challenge those who carry out health systems research. This research will provide the back-up support to the political leadership which dares to promote the democratisation of the health services. That will provide the key to promoting equality and equity in access to health services. It is a long, uphill task. ■

4 Equity and Mental Health in India (1947-2000): Role of State

R. Srinivasa Murthy

Introduction

Health and equity in India has a complex history. At one level equity has been expressed as a goal from the time of Independence while in reality this is far from the real nature of health care in India. The scope of the paper is to (I) review the general developments in health care in India from the point of Equity in Health, (ii) to consider the mental health developments and (iii) identify the role of the state in mental health care in India.

The NATIONAL HEALTH POLICY (1983) referred to the situation of health as follows:

"*the existing situation has largely been engendered by the almost wholesale adoption of health manpower policies and the establishment of curative centres based on the western models, which are inappropriate and irrelevant to the real needs of our people and the socio-economic conditions obtaining in the country. The hospital based disease and cure-oriented approach towards the establishment of medical services has provided benefits to the upper crusts of society, specially those residing in urban area. The proliferation of this approach has been at the cost of providing comprehensive primary health care services to the entire population, whether residing in*

the urban or rural areas. Further more, the continued high emphasis on the curative approach has led to the neglect of the preventive, promotive, public health and rehabilitative aspects of health care. The existing approach, instead of improving awareness and building up self-reliance, has tended to enhance dependency and weaken the community's capacity to cope with its problems. The prevailing policies in regard to the education and training of medical and health personnel, of various levels, has resulted in the development of a cultural gap between the people and the personnel providing care. The various health programmes, have by and large, failed to involve individuals and families in establishing a self-reliant community. Also, over the years, the planning process has become largely oblivious of the fact that the ultimate goal of achieving a satisfactory health status of all our people cannot be secured without involving the community in the identification of their needs and priorities as well as in the implementation and management of the various health and related programmes".

The developments of the last two decades, since the acceptance of the National Health Policy(1983) by the Parliament show that the state support for public health services have decreased. There is greater role for the private sector and less investment in the public sector.

For example, the **World Health Report 2000**, of the World Health Organisation has reported that the total expenditure on health is 5.2%. However, the public expenditure as percentage of the total expenditure of health is only 13%, with the private expenditure providing 87% of the total expenditure. The per capita health expenditure at official exchange rate is only $23, as compared to $3724 (USA); $1911(The Netherlands); $1836 (Canada); 1601(Australia); and $1193 (U.K).

A recent review of the health care in India by the **World Bank(1999)** identifies the factors for lack of health progress in India as follows:

- a population growth rate that puts a strain on government resources;
- per capita public health expenditures that are half of those of comparable countries and one-third the estimated cost of essential package of health services;
- inadequate funding of programs used mainly by the poor, and limited access for the poor to the programs that are available;
- insufficient provision of drinking water and sanitation;
- poor quality of service, as a result of shortages, absenteeism, improper staff behaviour, unrealistically large workloads, and low staff morale, and consequent underutilisation of facilities;

- inadequate mobilisation of private and NGO resources;

- excessive focus(until recently) on sterilisation and use of financial incentives to achieve targets; and

- inadequate focus on maternal and child health.

In India, throughout the last 53 years of Independence, it would be sappropriate to note that there was a focus on SELECTIVE health care and not total health care. In spite of the shift from unipurpose health workers to mutipurpose health workers, as early as 1972, the approach has been on specific diseases or programmes rather than total health.

Some examples will illustrate this.

(i) Kerala is often held up as an example of success in health programming to bring down public health indicators of mortality (IMR.MMR), longevity etc. In addition, the female literacy and the political system are given credit for all the positive developments. However, Kerala currently has the highest rates of suicide and high per capita consumption of alcohol besides high morbidity of non communicable diseases. No one asks the question, why have the measures, so successful in bringing down MMR,IMR etc not addressed the large health morbidity? There is actually an effort at glorifying the achievements and not looking at the total health of the community.

(ii) The central government health scheme started in 1954, had about 4 million beneficiaries in 1999. The expenditure for this relatively healthy population was Rs. 2200 million, giving a per capita expenditure of Rs.550/-. However, the per capita amount allocated to the general population in the public sector is less than 10% of this amount. It looks like the "rich" deserve better health investment than the poor. In addition, there is no attempt to learn and transfer the experience of providing comprehensive health care to a population of employees, to other population groups, especially the poor people.

(iii) The recent World Bank loans for health programmes have been mainly disease control projects like that for HIV/AIDS, Tuberculosis, Leprosy. It is only in the recent times there is a shift towards state health reform projects (World Bank, 1999).

Reviewing the health development in India one is compelled to conclude that equity has been low on priority. The Workshop on "Health Equity-Effecting change" is occurring at a crucial time point in India. As a result of a number of

factors, there is a REAL danger of the State "disowning" its responsibility for the health of the people. In some ways, even intellectuals and medical professionals are indirectly contributing to this "disowning" of responsibility by the state. The argument forwarded, as in the case of energy sector and other public sector services, is that the inefficiency is a good enough reason to shift the responsibility of the public sector to private sector.

I want to argue and present evidence to say that this is not in the interest of the poor, who are the people who will not get care if the state does not own its responsibility.

I will present some examples of the events of recent times to support this argument. I hope that the workshop will define or redefine the role of state in the health sector and not allow the state to give up its responsibility.

Example 1

The World Bank document(May 2000) titled SOCIO-ECONOMIC DIFFERENCES IN HEALTH, NUTRITION AND POPULATION by Gwatkin et al (World Bank, 2000) presents the data from its multi-country Demographic and Health Survey (DHS) program. There are three pages of data in the document. The first table refers to the total population and gives data relating to the IMR, U5MR. Children stunted etc for the poorest, second, middle, fourth and richest quintile groups.

What is striking is that there is a 2 to three fold disadvantage in the poorest group of the population as compared to the richest.

In second table, the male female ratios are given. The differences across the income groups persists for both the sexes and in addition women do poorly in all the groups.

The third table gives the differences between the rural and urban groups. It is seen that the poorest in the urban areas are worse off than the rural group of comparable income status.Under the item of delivery by a trained person, the difference is 6-7 fold, in delivery by a doctor the difference is 12 fold.

What is clear is that the poor are getting a raw deal in the current set up. There is no EQUITY in terms of health across the income groups.

Example 2

REDUCING INFANT MORTALITY AND FERTILITY, 1975-1990, by Measham et al (1999) (Economic and Political Weekly, 34 (May 29),1359-67). This review of the infant mortality and fertility reviews the performance at the all India and State levels. They conclude, on the basis of the data, that while income does have some influence on health outcomes,

technical progress and other factors are substantially more important.

Example 3

In the July 24 issue of the INDIA TODAY there is a heart rending story of Mr. Govind Singh who was found to have HIV positive status and was left to die in an animal shelter by the community. In the story the factors that stare at us are (i) Govind could not afford the repeat test costing Rs.700/; (ii) ignorance of the village population; (iii) lack of primary care services; (iv) lack of concern by the medical team (Doctors response: What can we do? Govind's own family members were keeping him in the animal shelter). As the story goes, Govind died, but his wife continues to carry the stigma and burden. "She should go for a test, otherwise people will treat her like an AIDS patient". But she does not have the money for the test. Where are the services for the poor?

Example 4

Privatisation of Hospitals

In the same issue, July 24, in the Web Exclusive of 'India Today' there is a story under AID FIRST, which presents in a positive manner the privatisation of the hospitals in Madhya Pradesh. Briefly, the story goes on to describe how the hospitals are being handed over to the public and the new management is raising money selling/ leasing land or charging money from the public. The story has a picture of a STATE OF THE ART facility for an intensive care unit costing Rs.70 lakhs! This amount came from the auction of 46 shops which fetched Rs. 1.1 crore.

The story states, "a citizen's committee collected donations and restored the hospital to its former glory". Are costly ICUs the need of the common man? Is this what the State should be doing?

Example 5

Transparent Government not to Introduce Helmets

This is the news item from Bangalore, July 26,2000. The gist of the story is that because of public resentment the state has decided to not insist on the helmets for scooterists and motor-cycle raiders. The minister states, as per the TIMES OF INDIA story, that there will be allegations of nexus between the helmet manufacturers and the Government".

Can we leave to the politicians our health if they are going to allow a few vociferous people sto decide public health issues?

Example 6

Water Everywhere -Not a Drop to Drink

The ECONOMIST in its March 25th 2000 report presents the distribution of

investment in INFRASTRUCTURE projects with private participation in developing countries as follows, during the 1990-98 period

Telecom	$200+ Billion
Energy	$170+ Billion
Transport	$ 80+ Billion
Water and Sanitation	$ 25+ Billion !

The figures speak for themselves.

Example 7

Epidemiological Model for Health Policy Analysis

The International Federation of Red Cross and Red Crescent Societies' recent WORLD DISASTERS REPORT focuses on PUBLIC HEALTH(2000). In one of its section(appendix 2) it presents the data relating to the investments in different aspects of health.

From the diagram it is clear that INVESTMENT IN PUBLIC HEALTH PAYS OFF. For example with 92% of the US health budget going into health infrastructure, drugs and administration the impact on reduction of mortality is only 11%. In contrast, with 5% investment in Public Health/behaviour modification the impact is 62%.

If this were true for a rich country, the benefits of public health expenditure can be greater in a country like India.

In summary, I want to plead that by a combination of factors, the STATE is decreasing its responsibility for the public health of the population. Privatisation of the various types will lead to setting up of ICU s and not lead to improving the water supply, sanitation, food safety and environmental control which have a greater impact on the health of the poor. It is important for us professionals to charge the STATE TO TAKE RESPONSIBILITY FOR THE ESSENTIALS OF HEALTH OF THE POPULATION. The decisions cannot be left only to public opinion, or to the funding agencies and certainly not to the private sector which has only the profit motive and would rather see the rich-poor divide widen rather than bridge the gap.

The next section of the article reviews the mental health care developments in terms of (i) what has happened since Independence, (ii) evaluation of the developments and (iii) how future mental health programmes should be planned in the country.

Mental Health Care in India (1947-2000)

During the last 50 years, the place of mental health as part of the general health has significantly changed. From a situation of no organised mental health care at the time of Independence (except for 10,000 psychiatric beds for 340 million population, which was one-hundredth of the facilities

in U.K. at that time), currently, mental health issues are actively seen as a public agenda in the various forums. Some of the examples are (i) the formulation of the National Mental Health Programme (1982), (ii) integration of mental health with primary health care at the district levels, (iii) the adoption of Mental Health Act, in 1987, and Persons with Disabilities Act in 1995, (iv) Supreme Court judgements about mental hospitals and attempted suicide, (v) voluntary agencies initiatives in the areas of self-help groups, rehabilitation, drug dependence and suicide prevention and (vi) wide media coverage of mental health issues (DATE on radio in 1992, Mindwatch on TV in 1997). The overall impact has been the movement to recognise mental health as an important issue in the community and in the services to move away from mental hospital care to care in the community.

Scope of Mental Health

The scope and importance of mental health ranges from care of the ill to the promotion of mental health. One of the earliest Indian psychiatrists to clearly outline this was Govindaswamy in 1948:

"The field of mental health in India has THREE objectives. One of these has to do with mentally ill persons. For them the objective is the restoration of health. The second one has to do with those people who are mentally healthy but who may become ill if they are not protected from conditions that are conducive to mental illness which however are not the same for every individual. The third objective has to do with the promotion of mental health with normal persons, quite apart from any question of disease or infirmity. This is positive mental health. It consists in the protection and development of all levels of human society of secure, affectionate and satisfying human relationships and in the reduction hostile tensions in the community."

The above three levels of activities continue to be relevant at the beginning of the new Century.

The developments in the 20th century have changed dramatically the concepts of mental health care. As a result of new knowledge about mental disorders, there is an increased availability of a wide variety of treatment choices and a better understanding of prevention of mental disorders and promotion of mental health. Overall, there has been a shift from mental illness to mental health (Srinivasa Murthy, 1993).

The period of 1947-2000 can be divided into four phases, namely, (i) 1947-1975;(ii) 1975-1982 (iii) 1982-1990 and (iv) 1990-2000.

Development of Mental Health Care-1947 to 1975

One of the earliest references to mental health care in India is the report in the INDIAN MEDICAL REVIEW (1938). At that time it was noted that there are 17

mental hospitals in British India with an accommodation for 8425 patients, but the number of patients actually confined in the hospitals in 1936 was 11,792. There was overcrowding in almost all the hospitals, but it was more acute in Madras, Bombay and the United provinces.

The dominant force in mental health development in the first phase was the policies relating to primary health care. Beginning with the BHORE COMMITTEE REPORT (1946) mental health has been part of the general health planning in the country. The HEALTH SURVEY AND DEVELOPMENT COMMITTEE was set up by the colonial Government in 1943 under the chairmanship of Sir Joseph Bhore. This committee's recommendations provided an almost revolutionary alternative to the existing health system in the country. The guiding principles of the committee were:

1 No individual should fail to secure adequate medical care because of their inability to pay for it.

2. Health programmes must from the beginning lay special emphasis on preventive work.

3. The need is urgent for providing as much medical and preventive care as possible to the vast rural populations of the country because the received medical attention is of the most meagre description although they pay the heaviest toll when famine and pestilence sweeps through the land; and

4. The doctors of the future should be a social physician attracting the people and guiding them to a healthier and happier life.

The major recommendation of the Committee was for the setting up of infrastructure in the rural areas with the primary health centre as the chief focus. The committee laid down the staffing criteria for each unit population of 40,000.

The observations and recommendations of the Bhore Committee on Mental Health were as follows:

"..... even if the proportion of patients be taken as 2 per thousand population in India, hospital accommodation should be available for at-least 8,00,000 mental patients as against the existing provision for a little over 10,000 beds for the country as a whole. In India the existing number of mental hospital beds is in the ratio of one bed to about 40,000 of the population while in England, the corresponding ratio is approximately one bed to 30,000 population".

The proposals for mental health care were (a) The creation of mental health organizations as part of the establishments

under the Director General of Health Services at the Centre and of the Provincial Directorates of Health Services; (b) the improvement of the existing 17 mental hospitals and the establishment of two new institutions in the first five years and of five more during the next five years; (c) the provision of facilities for training in mental health work for medical men in India and abroad and for ancillary personnel in India and (d) the establishment of the Department of Mental Health in the proposed All India Medical Institute.

The next Health Review Committee to review the health situation in the country was the MUDALIAR COMMITTEE in 1962. This Committee under the heading of MENTAL HEALTH, reviewed the progress made subsequent to the Bhore Committee, i.e., in the period of two decades, as follows:

"reliable statistics regarding the incidence of mental morbidity in India are not available. It is believed that an enormous number of patients require psychiatric assistance and service.... As against the total need of the number of beds available in mental hospitals in India is only 15,000. There is hardly any provision for the treatment of psychosomatic diseases in general hospitals" .

The recommendations made were under three heads, namely, general, training, research.

In the curative field recommendations to start (i)in-patient departments at lay hospitals; (ii) independent psychiatric clinics or mental health clinics and (iii) institutions for mental defectives was suggested. In the area of training the following were identified as important, namely (i) training and mental health personnel; (ii) orientation in mental hygiene of such professional groups as pediatricians, school teachers , nurses and administrators; (iii) orientation in mental health for all medical and health personnel; (iv) for meeting the acute shortage of psychiatrists, upgrading of the Ranchi Mental Hospital into a full fledged training institutions additional to All India Institute of Mental Health, Bangalore and (v) arranging that ultimately each region, if not each state, become self sufficient in the matter of training mental health personnel as per their total requirements.

An important outcome of this Committee recommendations was the setting up of a number of district psychiatric units in the different parts of the country and the creation of a mental health advisory group at the Ministry of Health.

The SRIVASTAVA COMMITTEE (1974) was the next major health committee to review the progress of health in the country and suggest plans for the future. This committee came into operation at a time when primary health care was receiving international attention.

The report of the committee " PLAN FOR IMMEDIATE ACTION" does not contain any specific proposals for developing mental health programmes. One of the important outcomes of this committee's recommendation was the Community Health Volunteer (CHV) scheme. The CHVs were expected to be from the committee and provide services to about 1000 population. The training of CHV's contained component of mental health. Out of the total training of 200 hours, one hour was kept for mental health. One of the 12 chapters in the CHV manual was also devoted to the recognition and management of mental health emergencies and problems.

The WHO conference at ALMA ATA, 1978, was a major event in the international health planning. This international conference in which India took an active part has come to be recognised as the turning point in the organisation of health services in developing countries. The term HEALTH FOR ALL by 2000 (HFA 2000) has become the focus of new activities and the reorientation of health programmes around the globe. In view of this, the inclusion of Mental Health as one of the components of primary health care in the recommendations of this conference was significant.

The NATIONAL HEALTH POLICY (NHP) (1983) was adopted by the Parliament to provide a new direction for health planning in India. One of the main recommendations was the increased emphasis on community participation and empowerment of the community for health. The NHP (1983) refers to mental health care as follows:

"Special well coordinated programmes should be launched to provide mental health care as well as medical care and also the physical and social rehabilitation of those who are mentally retarded, deaf, dumb, blind, physically disabled, inform and the aged".

Growth of Mental Health Services in India

Mental Hospitals

Till about the middle of 1970s the growth and development of mental hospitals was the main approach for the provision of mental health services. Institutions for the mentally ill that were in existence at the time of Independence were at Madras (1794), Varanasi (1809), Mental Observation Ward (1817), Dharwad (1845), Bareilly (1862) Ahmedabad (1863), Visakapatnam (1863), Kozhikode (1872), Tezpur (1876), Ratnagiri (1886), Baroda (1898), Thane (1902), Nagpur (1904), Hyderabad (1907), Yervada, Pune (1907), Jaipur (1912), Trichur (1914), European Mental Hospital (1918), Mental observation ward, Bhawanipur, Calcutta (1922), Indian Mental Hospital, Ranchi (1925); Indore (1927), Munkundu mental hospital, Calcutta (1932), Gwalior (1935),

Bhagia Unmand Ashram, Calcutta (1935), Bangalore (1937), Jodhpur (1940), Lumbini Park, Calcutta (1940); Bhavnagar (1942), Jaipur (1944) .

In the post-independence period, the major psychiatric hospitals that were built were at Amritsar (1950), Goa (1957), Bhuj(1957), Jamnagar (1959), Jammu (1964), Shahadra, Delhi (1966), Pavlov Hospital, Calcutta (1966), Behrampur (1980) and Purulia (1998).

The growth and development of the mental hospitals has been very unsatisfactory. Most of the mental hospitals have remained undeveloped and unsatisfactory in terms of the services provided and the facilities for care. A recently completed survey of the mental hospitals, by the National Human Rights Commission (NHRC, 2000) present a picture of neglected hospitals and low level of care to the mentally ill persons. A large part of the stigma about the mentally ill comes from the poor conditions of the mental hospitals. The following developments with regard to the mental hospitals emphasise the urgent need to modernise the mental hospitals.

At times, professionals and the public think of the very poor conditions of mental hospitals as an essential part of mental hospitals. That this does not have to be so was shown by the voluntary organisations in India. This was achieved by the effective use of the public interest litigation (PIL) provision in the Indian legal system. Starting with the first PIL in 1982, relating to the Ranchi hospital, was soon followed by the Shahadra hospital in Delhi (1983), mental hospital, Trivandrum (1986), jailing of the mentally ill in West Bengal (1989), Ranchi hospital (1989), Gwalior hospital (1993), Tezpur mental hospital, Assam, (1994), mental hospital in Trivandrum (1996) and Agra mental hospital (1994) became subject of judicial process. In most of these cases, commissioners were appointed and changes outlined to protect the rights of the mentally ill and to provide mental health care.

The NHRC (2000) report on the mental hospitals of India is a monumental effort, carried out with dedication, to document systematically the current situation of the mental hospitals. Such an effort urgently needed to describe the baseline situation can be evident the following findings of the Report. In view of the importance of the findings some relevant portions are quoted from the Report, relating to 37 government psychiatric hospitals.

"38% of the hospitals still retain the jail-like structure that they had at the time of inception ... nine of the hospitals constructed before 1900 have a custodial type of architecture, compared to 4 built during preindependence and one post-independence ... 57% have high walls ... patients are referred to as 'inmates' and persons in whose care the patients remain through most of the day are referred to as

'warders' and their supervisors as 'overseers' and the different wards are referred to as 'enclosures'.(p.32) .... overcrowding in large hospitals was evident ... (p.34 ... the overall ratio of cots:patient is 1:1.4 indicating that floor beds are a common occurrence in many hospitals (p37)... in hospitals at Varanasi, Indore, Murshadabad and Ahmedabad patients are expected to urinate and defecate into open drain in public view (p38)... many hospitals have problems with running water. .storage facilities are also poor in 70% of hospitals ... lighting is inadequate in 38% of the hospitals ... 89% had closed wards while 51% had exclusively closed wards... 43% have cells for isolation of patients (p.39)... leaking roofs, overflowing toilets, eroded floors, broken doors and windows are common sights (p.44)... privacy for patients was present in less than half the hospitals ... seclusion rooms were present in 76% hospitals and used in majority of these hospitals ... only 14% of the staff felt that their hospital inpatient facility was adequate (p.47)... in most hospitals case file recording was extremely inadequate ...less than half of the hospitals have clinical psychologists and psychiatric social workers... trained psychiatric nurses were present in less than 25% of the hospitals ... (p.48)... even routine blood and urine tests were not available in more than 20% of hospitals... 81% of the hospital in-charge reported that their staff position was inadequate(p.54)." The report notes "the deficiencies in the areas described so far are enough indicators that the rights of the mentally ill are grossly violated in mental hospitals" (p.50).

As recommended by the NHRC, there is an urgent and massive need for changes in the situation relating to mental hospitals, to become centres of care and treatment rather than be custodial institutions. The above condition of the mental hospitals is a reflection of the low priority of mental health and the lack of awareness in the policy makers and administrators. No modern country can be proud of the conditions described in the NHRC(2000) Report.

General Hospital Psychiatric Units

The growth and development of general hospital psychiatric units in India is an important change in the field of Indian psychiatry. (Wig; 1978). Wig refers to it as a slow and silent change but in many this was a major revolution in the whole approach to psychiatric treatment in our life time (Wig, 1978). The introduction of these units as a method of mental health delivery system has very important implications for the development of mental health service in the country. They have given a big push not only for the greater acceptance of psychiatric services by the general public but also changed the mental health scene in terms of training of mental health professionals and research work. The existence of GHPU in the general hospitals, though resented initially because viewed as mental hospitals coming to general hospitals, were very soon however accepted as valuable partners in the total health care system. The GHPU have a number of advantages over traditional mental hospitals. Some of them are (i) situated right in the community and they are accessible and easily approachable , (ii) families can easily visit and relatives can stay with the disturbed patients, (iii) there

is no stigma of mental hospitals, (iv) there are no legal restrictions on admission or treatment, (v) proximity of other medical facilities ensure thorough physical investigations and early detection of associated physical problems. This has brought new hope to patients. The other most important spin off has been the starting of the postgraduate training centres.

District Psychiatric Units

The development of district psychiatric units recommended by a number of health committees notably the Mudaliar Committee has been very slow and uneven. At present every district in Kerala and Tamil Nadu has a district psychiatric unit. However the situation in the other states of India especially in the northern and north eastern states is very unsatisfactory.

During the first phase, specifically in the 1960-75, efforts were also directed to meet the shortage of facilities of trained personnel in a number innovative methods. Some of important ones are (i) involvement of family members in mental health care starting from Amritsar in the 1950s and a routine part of care in all parts of India; (ii) use of traditional methods of therapy like yoga at Bombay; and (iii) alternative approaches developed for the care of university students and school children.

1975-1982

The second phase of work can be called the period of integration of mental health with primary health care. There were many reasons for this integration of services. Firstly, the recognition of large numbers requiring mental health services, both in the community and in the general medical clinics, especially among those living in the rural areas. Secondly, the limited number of psychiatrists and other mental health professionals to provide care. Thirdly, the emerging integration of all health programmes from the vertical programme model to multipurpose model. Fourthly, the international development of primary health care as the approach to organise health services. Fifthly, the recognition of the importance of early recognition and treatment to prevent chronicity. Lastly, the goal of continuity of care and integration of the mentally ill into the community could be achieved by the integration of mental health with general health services.

The **integration of mental health with primary health care** occurred at two levels, namely the training of the general practitioners and the training of the primary heath care personnel working in the rural health services.

General Practitioners (GP) Training: A large number of researchers in the country have studied the magnitude of mental

health problems in general health services (Srinivasa Murthy et al 1976, Harding et al, 1980, Gautam et al, 1980, Shamsunder et al, 1986, Adityanjee et al, 1986, Sen, 1987, Seshadri et al, 1988, Sriram et al, 1988, Channabasavanna et al, 1995, Amin et al, 1998, Patel et al, 1998).

Professionals have made systematic attempts to develop approaches to provide mental health training to the general practitioners. This method is specially suited to the needs of the urban populations.(Shamsunder et al, 1978, Shamsunder et al, 1980, Gautam et al, 1980, Shamsunder et al, 1983, Devi, 1993, Bhattacharya et al, 1993). General practitioners form a major part of the total number of more than 300,000 doctors in the country. They are providing care in the private sector and form an important resource for mental health care in India. They work both in rural and urban areas and their services are utilised both by the rich and the poor. In India, involvement of GPs have been carried out both in an organised manner and by informal contacts. The latter takes place in the form of (a) courses by psychiatrists organised by such professional agencies like the Indian Medical Association, (b) informal discussions that naturally take place between the referring general practitioner and the psychiatrist either in service or in private consultation. When there is a healthy mutual professional liaison it further strengthens the efficacy or formal, organised training programmes.

The more formal continued effort in training GPs in psychiatry has been going on at NIMHANS, Bangalore from 1975 (Shamsunder et al, 1978, Shamsunder et al, 1980, Gautam et al, 1983, Shamsunder et al, 1983, Shamsunder, 1986) with accumulated experiences of about 10 courses of varying types. They varied in the form, frequency and duration. In addition, an ICMR collaborative research effort was undertaken in 1982-84 involving 3 centres (namely Bangalore, Hyderabad, and Vellore) successfully testing the method and material developed at NIMHANS, Bangalore. (ICMR,1982).

The findings of these experiences are (i) GPs are generally poor corresponders, responding poorly to postal and/or newspaper communication, with a response rate of about 20%. However, they respond more positively on personal contact. This was specially effective when liaison service was available; (ii) a GP tends to jealously protect his unique professional freedom and dreads to function as an extension or extra pair of hands for specialists; (iii) the GP expects their patients to be referred back to their care when they refer patients, (iv) specialists plan of management is often not practicable in the primary care setting of general practice, (v) neurosis, depression, alcohol related problems, sexual problems, psychosomatic and somatopsychic problems are overwhelmingly represented in clients of general practice, and (vi) the GPs seek to

acquire practical skills rather than acquire theoretical knowledge .

This area offers a major avenue to enhance the mental health manpower in the country with comparatively minimal inputs. In the coming years, this area is expected to receive greater, nationwide professional support. Working in this field is easier compared to similar work in public sector because the GPs are eager to acquire skills by which to achieve both professional and consumer satisfaction. And therefore, it is much easier for the health professionals to establish a working and teaching relationship with the GPs to the ultimate benefit of the community. In the last few years, World Health Organisation has not only systamatically studied the psychological problems in general health care (Ustun and Sartorius, 1995) but also developed a primary health care version of ICD-10 (WHO, 1996) and training material suitable for general practitioners.

Rural Psychiatric Services

The organisation of essential mental health services as an integral part of primary health care has been a major development in the country. The efforts were started by two centres in the country, namely, Bangalore and Chandigarh. Currently, the programme is covering over 25 districts, in 22 states of the country providing services to over 40 million of the population.

The programme of community psychiatry was launched in 1976 at the NIMHANS, Bangalore. The aim of the rural project was to develop suitable training programmes for the doctors and the multipurpose workers from the various primary health centres in the state of Karnataka, so that after their training PHC personnel could provide basic mental health care (detection and management of epilepsy and psychosis). The team initially studied the needs of the rural population in one primary health centre (1975-1980) (Chandrasekar et al, 1981, Parthasarathy et al, 1981). This was carried out by identifying mentally ill persons in their homes through key informants and those attending the general health facilities (Kapur and Issac, 1978, Issac and Kapur, 1980).

These efforts of understanding the needs and methods of care in the community were followed by pilot experiment to integrate mental health with primary heath care in one PHC with a population of 100 000 (1980-86) (Issac et al, 1981, Issac et al, 1982). Following this a model programme covering a district with a population of 2 million (Issac et al, 1986, Naik et al, 1994, Naik et al, 1996).

The Chandigarh efforts were initiated in 1975. This efforts was the outcome of the observation of the limited utilisation of psychiatric services from the hospital (Khanna et al, 1974, Srinivasa Murthy et

al, 1974, Srinivasa Murthy et al, 1977, Wig et al, 1979).The aim was to develop a model for rural psychiatric services . This effort was further supported by the WHO efforts in this area. WHO Project Strategies For Extending Mental Health Care (1976-1981) was a multicentered project carried out in 7 geographically defined areas in Brazil, Colombia, Egypt, India, Philippines, Senegal and Sudan and designed to develop and evaluate alternative and low cost methods of mental health care (including training methods) in developing countries (Sartorius and Harding, 1983). The basic approach adopted in this model is to integrate mental health with general health services and provide basic mental health care as part of primary health care.

At the Chandigarh Centre this project provided opportunities to understand the needs of the rural mentally ill and methods of proving care to them utilising the existing primary health workers and physicians (Srinivasa Murthy et al, 1978, Wig and Srinivasa Murthy, 1978, Wig et al, 1980, Wig and Srinivasa Murthy, 1980, Wig et al, 1981a, Wig et al 1981b, Srinivasa Murthy and Wig, 1983, Ignacio et al, 1983, 1989).

The results of this project completed in 1981 demonstrated the feasibility of integrating mental health with general health services by choosing priorities and developing proper training programs for the health personnel. However , this requires (i) the commitment of health authorities to include mental health as part of PH care; (ii) provision of adequate drugs, (iii) the availability of support and supervision from the PHC doctors and (iv) further crystallization of knowledge regarding the treatment schedules to be used in the community without daily and continuous supervision of specialized staff.

National Level Initiatives for Mental Heath Programme

One of the earliest efforts to develop mental health programme for the country was in the 1960s. The Mental Health Advisory Committee constituted in 1962 met in 1963, 1965 and 1966 to consider the various aspects of mental health needs in the country. The areas that received considerations were (i) the mental health bill, (ii) ambulatory treatment, (iii) training of mental health personnel, (iv) starting of epilepsy clinics, (v) improvement of mental hospitals, (iv) standardisation of forms and records for mental health services (vii) need for drugs (Ministry of Health,1964-66). The need for a comprehensive plan to organise nation wide services has been often expressed. The need for a clear plan led to the formation of a group of 3 psychiatrists to assist the President of IPS to prepare a blue print for national level of planning of Mental Health.

However, it was only during 1981, the Directorate General of Health Services

organised a National level workshop to consider a draft mental health plan his was held at AIIMS, New Delhi under the convenership of Professor N.N. Wig, in July 20-21, 1981. The essential aspects of the suggested plan following the workshop is to stimulate services both in the pepiphery and the Center. This was planned to be achieved by suitably integrating mental health care at all levels of health services.

1982-1990

National Mental Health Programme

The National Mental Health Programme (Government of India, 1982) is the outcome of the developments in providing mental health care through different methods as well as the overall goals of health care in general. The first concerted effort to formulate a national programme was held in July 1981. Over seventy mental health related professionals met at New Delhi and reviewed the needs in the areas of mental health and possible approaches. The result of this workshop was a draft NMPH for further consideration. On 2August 1982, a small group of experts met to consider the revised document and finalise the same. This document was presented to the central council of health and Family Welfare at its meeting between 18 and 20 August 1982. This body, the highest policy - making body in the area of health, recommended the NMHP for implementation.

The objectives of the programme are:

1. To ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged of the population .

2. To encourage application of mental health knowledge in general health care and in social development.

3. To promote community participation in mental health services development and to stimulate effort towards self-help in the community.

The specific approaches suggested for the implementation of the NMHP are:

1 Diffusion of mental health skills to the periphery of the health service system.

2. Appropriate appointment of tasks in mental health care.

3. Equitable and balanced territorial distribution of resources

4. Integration of basic mental health care with general health services

5. Linkage to community development.

The Central Council of Health and Family Welfare in August1982 recommended that: (i) mental health must form an integral part of the total health programme and as such should be included in all national policies and programmes in the field of health, education and social welfare and (ii) realising the importance of mental health in the course curricula for various levels of health professionals, suitable action should be taken in consultation with the appropriate authorities to strengthen the mental health component. Similar recommendations were made in October 1995 by the same body on reviewing the progress of the National Mental Health Programme. This latter recommendation resulted in the DMHP programme in the country.

From the time of the formulation of the NMHP in August 1982, in the last two decades the following initiatives and activities have been taken up:

1. Sensitisation and involvement of the state level programme officers;

2. Workshops for voluntary agencies;

3. Workshops for mental health professionals, namely psychiatrists, clinical psychologists, psychiatric social workers, psychiatric nurses;

4. Training programmes in public mental health for programme managers;

5. State level workshops for the health directorate personnel; development of models of integration of mental health into primary health care up to the level of the District;

6. Preparation of support materials in the form of manuals, health records for different types of health personnel; and health education materials;

7. Training programmes for the teachers of undergraduate psychiatry (Reddy et al, 1986).

These developments were the result of efforts by a large group of mental health professionals. Gautam (1985) completed a comparison of two different training programmes and its effectiveness. Manuals of mental health were prepared at the different centres namely, Bangalore (Wig and Srinivasa Murthy, 1980, Wig and Parhee, 1984, Sharma, 1986, Srinivasa Murthy et al, 1987, Issac et al, 1988, Srinivasa Murthy et al, 1988, Sell et al, 1989, Sriram et al, 1990, Issac et al, 1994). Systamatic efforts were made to evaluate the effect of the training programmes utilising different methods (Sriram et al, 1989, Sriram et al, 1990a, Sriram et al, 1990b, Sriram et al, 1990 c) Bangalore centre has also prepared training video for use in the above training programmes along with a variety of evaluation tools.

Of the many initiatives, the integration of mental health with primary health care at the level of the district is the most important. This initiative has the community based and community intensive approach. (Issac et al, 1986, Naik et al, 1994, Naik et al, 1996, Srinivasa Murthy, 1992). The essentials of the District Mental Health Programme, as developed at the Bellary District and currently under implementation in two dozen districts in the country (with central government support) are:

- a decentralised training programme for the existing health personnel on essentials of mental health care at the district level;
- provision of mental health care in all general health facilities;
- involvement of all categories of health and welfare personnel in mental health care;
- provision of essential psychiatric drugs at all health facilities;
- a simple record keeping;mechanism to monitor the work of primary health care personnel in the provision of mental health care, a mental health team at the district level, for training of personnel, referral support and supervision of the mental health programme. The initial project at Bellary demonstrated the feasibility of providing basic mental health care along with primary health care.

1990-2000

During the last few years, the District Mental Health Programme (DMHP)has been launched at the national level. This was the outcome of the meeting of the Central Council of Health in 1995, and the recommendation of the Workshop of all the health administrators held in February 1996 at Bangalore. The DMHP was launched in 1996-1997 in four districts, one each in Andhra Pradesh, Assam, Rajasthan, and Tamil Nadu, with a grant assistance of 22.5 lakhs each. A budgetary allocation of Rs.28.00 crores has been made during the Ninth Five Year Plan period for the National Mental Health Programme.

The current programme envisages:

"a community based approach to the problem, which includes(I) training of the mental health team at the identified nodal institutes within the State;(ii) increase awareness in the care necessity about mental health problems; (iii) provide services for early detection and treatment of mental illness in the community itself with both OPD and indoor treatment and follow-up of discharged cases and (iv) provide valuable data and experience at the level of community in the state and Centre for future planning, improvement in service and research. The training of trainers at the State level is being provided regularly by the National Institute Of Mental Health and Neurosciences, Bangalore under the NMHP" (GOI, 2000).

The DMHP was extended to 7 districts in 1997-1998, five districts in 1998 and six districts in 1999-2000. Currently the programme is under implementation in 22 districts in 20 states as follows. Andhra Pradesh (Medak; Assam (Nagaon and Goalpara); Rajasthan (Seekar); Tamil Nadu (Trichy); Arunachal Pradesh (Naharlagun); Haryana (Kurukshetra); Himachal Pradesh (Bilaspur); Punjab (Muktsar); Madhya Pradesh (Durg); Maharashtra (Raigad); Uttar Pradesh (Kanpur); Kerala (Thiruvanthapuram, Thrissur); West Bengal (Bankura); Gujarat (Navsari); Goa (South Goa); Daman and Diu; Mizoram (Aizwal); Chandigarh; Manipur (Imphal East); Delhi (Chhatarpur). The recently initiated programmes all over the country can be expected to provide information about the practicability of this approach in different states with varying levels of primary health care infrastructure.

Mental Health Manpower Development

At the time of independence, there were only a handful of psychiatrists and no organised facility for training of psychiatrists in the country. The recommendation of the Bhore committee led to the establishment of All India Institute of Mental Health at Bangalore in collaboration with the existing Mental Hospital, Bangalore in 1954. From January 1955 the first postgraduate diploma in psychological medicine was initiated. Since then a large number of training centres have come up in about 40 centres. About 3000 qualified psychiatrists are working in different centres in the country. The number of psychiatric social workers is estimated to be around 600. The number of trained psychiatric nurses is around is about 600.

Of the 140 medical colleges in the country, about three quarter of the colleges have an academic department of psychiatry. In another quarter a psychiatrist functions as part of the general medicine department with no additional staff. The actual amount of training is grossly inadequate, as the minimum amount of training required as per Medical Council of India rules is only two weeks of training. Often this occurs in a distant mental hospital. This lacunae in giving adequate exposure to common mental disorders and competence and skills to diagnose and treat mental disorders is an urgent need. It is noteworthy that this need has been repeatedly expressed in a number of expert committees and other forums, without a significant change in the situation. The stagnation of training of undergraduates in psychiatry is in contrast to the improvements in establishing postgraduate training programmes in psychiatry.

Involvement of Families

The majority of the mentally ill live with the families in India. Families have been a part of the care programme for a long time. In the last 50 years, they following measures have been taken to involve them

by involvement in care during the period of hospitalisation; educational programmes for the family members; partnership between professionals and families and formation of self-help groups of families-support for the families caring for the mentally ill.During the first four decades since Independence, the focus was on utilising the services of the families to supplement the mental health care provided by the professionals.

During the 1990's, the movement to develop new programmes for family members and active professional involvement and partnership have been initiated. These are (i) family education (Viswanath and Padmavathi, 1992), (ii) family intervention, (Shankar, 1994, Nagarajiah, 1994, Bhatti and Verghese, 1995, Shankar, 1998), (iii) formation of self-help groups and greater support to families to become partners in care. (Shankar and Menon, 1991, Srinivasan, 1998, Srinivasa Murthy, 1999).

The focus of family interventions, to date, has been to build a relationship with caregivers based on understanding and empathy, focussing on the strengths of caregivers and assisting them to identify community resources, interventions to promote medication compliance, interventions to promote early identification of relapse and swift resolution of the crises, guiding families to reduce social and personal disability, guiding families to reframe expectations and moderate the affect in the home enviornment, guiding families to improve vocational functioning of the patient, emotional support to caregivers and development of self-help groups for mutual support and networking among families.(Shankar, 1998, Nagarajiah, 1998).

However, it is to be noted that a large scale initiative and state support to families is still to be achieved. India has the advantage of family support and it is important that we do not take the family support for granted and as being permanent. Without support to the families caring for the mentally ill there could be giving up of the role when there will be new challenges for the patients, professionals and the state. The specific needs of the families are (i) correct information; (ii) user-friendly domiciliary services; (iii) family support by visiting professionals during the long term care phase; (iv) financial support for carers; (v) income-tax and other welfare benefits and (vi) decrease of stigma and discrimination by the general community.

Community Involvement

A number of innovative programmes have been developed to utilise the community resources in the mental health programme. The CAMP approach for addressing the problem of drug depend-ence is one of them. This has been utilised by the teams in Rajasthan (for opium addiction) and

Tamil Nadu (alcohol dependence) (Ranganathan, 1996, Manickam, 1997). The other area in which volunteers have been utilised extensively is the suicide prevention programmes at the different centres in the country (Vijayakumar, 1994, Srinivasa Murthy, 2000). Another programme of importance is the school mental health programmes (Kapur and Cariappa, 1979, Kapur, 1997)

Public Mental Health Education

A notable feature of the Indian mental health experience is community education. Professionals have used the available media, especially the newspapers and magazines, radio, television to address the problems of drugs, alcohol, tobacco (DATE Programme) and mental disorders (MINDWATCH series on National television). The media persons also have focussed on the issues of mental hospitals, women in institutions, jails and mental retardation. A more recent addition to these activities is the television chat shows which often relate to mental health issues.

Traditional Practices

India has a rich history of traditional medicine, cultural beliefs and social practices of acceptance of the ill and personal adversities (eg.death) by use of social supports and philosophy of the religion. In a limited way Ayurvedic drugs have proved to be valuable, as much as the generation of antipsychotics, in the treatment of psychoses. The systems of yoga and meditation are well-recognised and used widely as stress management and treatment of emotional problems. At the community level there are a wide variety of practices regarding child care that are in harmony with the current mental health knowledge.

Other Developments

During the last five decades, along with the changes in the care of the mentally ill persons, there have been changes in the legislative area, programmes for persons with drug dependence and mental retardation. The Indian Lunacy Act 1912, was replaced by the Mental Health Act, 1987. The recently formulated Persons with Disabilities Act, 1995 included mental disorders as one of the disabilities. The development of services for the mentally retarded persons has shown a dramatic improvement. The National Institute for the Mentally Handicapped established in 1984 at Secunderabad has provided leadership in training of personnel, preparation of support materials for the different categories of mentally retarded and different functionaries and research. In the area of drug dependence, a new law, the Narcotics and Psychotropic Substances Act 1985 has come into effect. The drug dependence care programme has included (i) setting up of de-addiction centres; (ii) training of personnel for drug dependence care; (iii) support to voluntary agencies and (iv) monitoring of the drug dependence programmes by setting up regional and national co-ordination

centres. The area of rehabilitation is making beginnings in the country. Centres of day care, half-way homes and long-stay facilities are coming up gradually, as well as masters programme for training rehabilitation personnel at Richmond Fellowship Bangalore and at the Father Muller Hospital, Mangalore.

There is scope for prevention of mental and neurological disorders (WHO, 1989) and this area has not received adequate attention to date. Similarly the focus on promotion of mental health is still a less emphasised area.

International Developments

There is a major shift in identifying priorities in health from mortality to morbidity. Past emphasis on mortality had led to the ignoring of neuropsychiatric disorders for a long time as they are low in the cause of death lists. However, when disease burden is measurement includes time lived with disability, several of the neuropsychiatric disorders become the leading causes of disease burden world wide. The World Health Organisation-World Bank (1993) estimates of global burden of disease estimated the burden of neuropsychiatric disorders to be 8.5% in 1993. This was 11% in 1998. In high income countries, one out of every four DALYs was lost to a neuropsychiatric condition, while in low and middle income countries this group of conditions was responsible for one out of ten DALYs. (WHO, 1998, 1999, 2000). Of the ten leading causes of disease burden in young adults (in the 15-44 years age group) four were neuropsychiatric disorders. More specifically, unipolar major depression was the fourth leading cause of overall disease burden in 1990, while in adults aged 15-44 years it was the leading cause of DALYs, both in high income and in low and middle income countries. Alcohol dependence, bipolar disorder and schizophrenia were among the leading causes of disease burden in this age group in 1998.

WHO has identified this as a priority and called for greater attention to be paid to the growing needs of populations in the area of mental health. (WHO, 1999 a, b, c, d).

In recent times, mental health has received the highest recognition from international organisations. The most important is the initiatives by the World Health Organisation (WHO). The Director General Dr. Gro Harlem Brundtl and organised a meeting of experts on April 28-29, 1999, to set the WHO Agenda For Mental Health. This consultative meeting identified mental health as a priority for WHO's work in the coming years. The group emphasised the need for greater attention to causes of mental disorders, their prevention, as well as identification and implementation of best practices for the treatment of priority mental disorders (WHO, 1999 e). An important expression of this concern is the declaration of the

theme for the World Health Day 2001 as Mental Health. In addition the World Health Report 2001 will focus on mental health.

Another important development is the publication of the Surgeon General Report on Mental Health from USA in December 1999 (Surgeon General, 1999). This Report is the first of its kind, in the 40 years of publication of reports by the Surgeon General to be focussing on mental health. This document identifies the following areas for action under the section Vision for the Future (i) continue to build the scientific base; (ii) overcome stigma; (iii) improve public awareness of effective treatment; (iv) ensure the supply of mental health services and providers; (v) ensure the delivery of state of the art treatments, (vi) tailor treatment to age, gender, race and culture; (vii) facilitate entry into treatment and (viii) reduce financial barriers to treatment. Two important messages of the Report are:

- mental disorders are real health conditions;

- seek help if you have a mental health problem or think you have symptoms of a mental disorder.

Another important development is the forthcoming publication by the Institute of Medicine, USA, a monograph on mental and neurological disorders in developing countries. This monograph examines the evidence for the magnitude, burden, effectiveness of interventions and the research needs relating to developmental disorders, depression, schizophrenia, stroke and epilepsy. There is truly an international attempt to address the mental and neurological disorders in the developing and developed countries.

Evaluation

Evaluation of the progress of the first five decades has been presented elsewhere (Srinivasa Murthy and Wig, 1993). The positive aspects is the enhanced recognition and services available to the larger population. However, it needs to be noted that the programmes and initiatives have not really spread beyond the pilot programmes to the total population. There are large treatment gaps from the onset of illness to the seeking of professional help, with attendant contribution to chronicity, disability and burden to the community. (Rajkumar, et al, 1993, Shaji et al, 1995).

The rest of the world is discovering the value of mental health in primary health care and focussing efforts in this area. India which has had a lead in initiating integration of mental health in primary health care nearly a quarter of a century ago, has not done enough. Specifically, studies need to be carried out to understand the care processes and impact evaluation of the programmes. There is the

larger problem of chronic mentally ill in the community (Bhashyam, 1997, Agarwal, 1998, Wig, 1999). The stigma of mental illness awaits major initiatives to fight the discrimination experienced by the patients and their families (Wig,1987). The area of truly empowering the patients, families and communities towards the three goals of mental health namely promotion, prevention, and treatment is still in its beginning. There is a need for a Peoples Action For Mental Health in the country (Srinivasa Murthy, 1998).

Agenda for Future of Mental Health

1. The advances in the understanding of human behaviour and mental disorders justifies the optimism of developing meaningful and realistic mental health programmes. It is mandatory to bring the fruits of science to the total population of India.

2. The nature of mental health requires that actions and interventions be multidimensional involving a number of sectors, professionals and approaches.

3. The wide variations across the states of India demands that plans are developed for each of the states and union territories, besides a national plan and programme.

4. There is a need for a central level mental health organisation at the Ministry of Health and Family Welfare, New Delhi.

5. All the psychiatric care institutions, specifically the mental hospitals, should be upgraded in terms of trained personnel, treatment and rehabilitation facilities, living arrangements and community outreach activities.

6. All the medical colleges should have independent departments of psychiatry to ensure adequate undergraduate training in psychi-atry.

7. District mental health teams should be set up, as part of the district hospitals and the district health offices.

8. Integration of mental health with primary health care should be achieved to facilitate early identification of patients, regular treatment and reintegration into the community.

9. Monitoring mechanism to monitor the mental health of populations at the level of districts and sub units of districts should become part of the health information systems.

10. Support should be provided from the government for the families of the mentally ill persons in terms of community based services, financial support for care, formation of self help groups.

11. Enhanced involvement and aid to Voluntary agencies to take the number of initiatives towards promotion of mental health, prevention of mental disorders and treatment of mentally ill should provided.

12. Planned mental health manpower development by increasing the centres of training, creating opportunities for employment should be undertaken.

13. Development of programmes for public education through all available traditional and modern media should be taken up.

14. Research at the National, regional and local level to understand the prevalence, nature, course and treatment response should be supported.

15. There is an urgent need to understand the impact of social changes and developmental policies on mental health of the people.

16. National level institutions should take up the responsibility to develop and evaluate models of care, training of different categories of personnel and monitoring of the mental health programmes. ■

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5 Controlling MDR-TB: An Agenda Beyond Drugs

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This story begins with the 1987 publication of The World Bank "Financing Health Services in Developing Countries: An agenda for Reform" which proposed a global agenda. The policies recommended therein were strategically implemented in the form of cut budgets and privatized medical health services. The Epidemiological Bulletin of the Pan American Organization in 1991 reported the occurrence of almost 300,000 cases of cholera in 10 countries - the first cholera epidemic in the Americas in the 20th century[1]. Cornia et al[2] compiled compelling evidence from case studies showing a direct association between cuts in Government expenditure on health and other social services.

A general deterioration in health status was observed in 10 countries as manifested by higher morbidity especially from infectious diseases such as diarrhoea, pneumonia and tuberculosis. In India however the national sample surveys show no fluctuations either in the prevalence or incidence rates of TB[3] despite vigorous stabilization and structural adjustment programmes implemented fairly vigorously since 1993. Though this stability is partially attributed to a well conceptualized National Tuberculosis Programme (Banerjee, personal communication), the lack of a reliable epidemiological base

introduces not insignificant doubt to the veracity of this claim. Indeed it has recently been felt that multidrug resistant TB (MDR-TB) is on the increase and is likely to reach 'menacing proportions'[4]. Tertiary care hospitals in Western Maharashtra report prevalences ranging from 25-45% whereas community based figures are quoted to be between 3-11%.

Control Through Drugs

The National Tuberculosis Control Programme adopted by the country in 1963 espoused specific drug regimens as the sole measures to control TB. These "magic bullets" could be availed of during domiciliary treatment thus excluding extended hospitalization and subsequent economic wage loss to TB patients. Four decades later we are left sadder and wiser probing for answers.

The traditional public health school still attribute this solely to a biomedical system failure viz. non availability of anti-TB drugs, patient's irregularity and drop out from treatment regimens and a strange lack of knowledge of TB drugs and their regimens among our medical practitioners. The Revised National Tuberculosis Control Programme (RNTCP) adopted since 1993 aimed to rectify drug related deficiencies and while aiming atleast 80% drug availability also undertook the streamlining of sputum examination based diagnostic procedures and introduced a strategy of direct observed therapy (DOT). The latter implemented after an MDR-TB epidemic at a cost of $ 1 billion in New York for a small high risk population is now prescribed in all TB affected countries as the most cost effective and efficient method in impeding the development of drug resistant strains. During trials however several negative aspects of the DOT strategy (DOTS) have arisen. Firstly in view of the additional staffing required it is expensive to implement while patients find it burdensome to travel to a clinic everyday for months to avail of the treatment. They tend to stop treatment as soon as they feel better because of the inconvenience and problems of holding a job while in treatment and the loss of wages that this entails. On average an Indian TB patient spends Rs. 120-165 per month on DOTS treatment. There are now increasing complaints of inferior quality drugs being distributed at DOT centres with staff ill-equipped to deal with either counselling or drug induced complications[5].

By ignoring to recognize the patients' felt needs, DOTS in India can hardly be expected to control the problem of MDR-TB. In fact, its unintelligent application may encourage irregular treatment patient drop out and thus exacerbate the problem of MDR-TB. In this aspect the growing concern of treatment failures in category two patients on DOTS is justifiable (Dholakia - Personal Communication).

The pointer that **drug induced MDR** is a reality is experienced in Africa where MDR-TB is less common than in other parts of the world as is the number of patients who are treated with anti-Koch's therapy[6]. More recently Hoffner has also observed the transformation from drug susceptibility to drug resistance in a strain of *M.avium* **during** the course of treatment[7]. Even in the U.S., 12% of TB infections are resistant to at least one drug[6] whereas in South Africa, a study showed that at least 52% of drug resistant tuberculosis was caused by transmission of a strain that was drug resistant before initiation of treatment ie. primary resistance[8].

The paradigm of drug induced resistance is supplemented with one other. Whilst ineffective public health policies are contributory to the rise of MDR-TB, the Amsterdam Declaration of 1999 recognized that TB is linked more strongly with poverty and rapid social change more than any other major disease. 98% of annual deaths from TB and 95% of new cases are in the developing countries[6] many of whom face a dual onslaught of HIV-infection and MDR-TB. Rising poverty, the inability to consume two square meals a day has several implications for MDR-TB.

Basu et al[9] highlighted that efficacy of drugs including AKT is dependent on a 'minimal' nutritional status having an yet ill understood interplay with host immunity. Being nutritionally deprived means that the action of drugs will be less potent and that the disease may well progress to a drug non-responder state if not classical gene based drug resistant profiles of the TB germ.

In any event, the patient will shop for alternative treatment, face several episodes of unresolved disease and eventually die. Even if on the other hand, an appropriate second-line treatment is prescribed, its efficacy will not exceed 50%. This fact will not reveal itself until the patient has spent at least Rs.1.00 - 1.5 lakhs on treatment besides the additional loss of wages and time incurred. The social implications will be gross financial indebtedness for the patient and the family, stigma and possibly the death of a wage earner. Mismanagement in use of antimicrobials in India through self-prescribing, over-counter sales and medical malpractice will further ensure that primary resistance to even second-line drugs is high. The frequency of hearing reports of resistance to second-line drugs such as kanamycin is increasing particularly in HIV-TB patients[10]. The immunocompromise and debilitation in HIV patients is increased, as in nutritional deprivation and only serves to underscore the importance of good nutrition and intact immune resistance for effective drug action.

The probability of controlling drug abuse/ misuse particularly in developing countries

is extremely poor. Even in the U.S., state legislation to govern prescriptions has been opposed by physicians as interference in professional judgement[11]. One way of curbing this could be to link misuse of drugs statewise with receipt of central funds earmarked for public health. A selective withdrawal of some government subsidies in drug production, purchase and distribution maybe another avenue of control provided that it does not bring about inequitable accessibility to drugs that are needed. Rational use of AKT and second-line drug regimens depend on accurate surveillance but in the presence of a poor public health system a mere surveillance network however efficient, cannot be the sole panacea. This technical arm needs to be supported with the presence of an aware and informed citizenry, an accessible intense and integrated health system reaching to the grass root level and last but not the least a strong political commitment of governments to their citizen's welfare that allow practices like parallel imports of cheaper drugs or control of anti competitive licensing to come into their own[12].

Technical inputs such as early diagnosis and identification of contacts cannot by themselves affect the transmission of TB (and MDR-TB) or diseases that are precipitated by socio-economic malaise. Firstly, the sensitivity of diagnostic tests in chronic diseases such as TB is less than satisfactory. Secondly stretched financial resources go ill with screening of populations and development of increasing sensitivity in tests that are basically expensive. A very modest decrease in patients' numbers in the U.S. between 1955 and 1992 was attributed to a 15 fold increase in spending from $ 3 m to $ 75 m on tuberculosis research[13]. A nation with a crunch in financial resources for health is likely to have poor socio-economic indices and a population with a high element of relative risk. Therefore even in communities that implement essential public health elements of TB control, ongoing transmission of TB is bound to continue for a long time to come[14].

Despite mounting doubts, the RNTCP using DOTS claims to have successfully treated approximately 80% of patients in 20 districts of 15 states in India[15]. Treatment success rates are claimed to be more than double and death rates less than a seventh to those of the previous programme. A give away figure is the success rate of 89%-achieved in-patients with extra pulmonary TB. In a country where diagnosis of extra pulmonary TB is largely on a symptomatic basis with no consensus on laboratory based diagnosis, the figures of the so-called "cure rates" achieved are hard to swallow. Diagnosis of even pulmonary tuberculosis by simple sputum examination till recently enjoyed an average national sensitivity of only 25%[5]. This was true also of the municipal wards in the Island City of Bombay as recently as 1998. Yet case detection rates

for the first two quarters of 1999 show up as 43.2/100,000 with a target of 50/100,000 for sputum positive cases. The cumulative figures for sputum positive and negative pulmonary tuberculosis, on the other hand are 135/100,000 exceeding the target of 132/100,000 (Rangan, Personal Communication)! The authors have had for the same period access to the knowledge that whilst external experts dubbed the performance of Bombay Municipal Corporation (BMC) microscopy centres as "abysmal" the BMC technicians negated any effort at monitoring or upgrading of their performance. These `gratifying' cure rates originate from these very same public microscopy centres. This echoes the lament of D. Banerjee[16] where he states that "a major obstacle to assessing the performance of the RNTCP is that very scanty information and that too of questionable validity is available".

Datta and Mohan[17] similarly indicate the lack of any reliable epidemiology of MDR-TB in India. No continuous quality control between even referral laboratories has been undertaken. The test procedures are never fully disclosed and no effort is being made to evolve rapid tests for screening for drug resistance. The problem of MDR-TB will never be reflected accurately in the RNTCP since claims indicate that 30% of patients (probably a large part comprising of problematic cases) are turned away from the DOT treatment centres[5] by virtue of their place of residence or disease complications or previous history of refractoriness to anti-TB drugs. The terms DOTS **treatment** and DOTS **coverage** are therefore not always synonymous.

Beyond Drugs

The current stage of globalization, dating from the 1960s is distinguished by the geographical breadth it encompasses, the frequency and intensity of human interactions that are taking place and the degree to which thought processes have been subservient integral to these interactions. The impact on human society and its health is unprecedented[18]. At least 30 new infectious diseases have emerged in the last 20 years.

Globalization creates pressures on national governments to integrate and compete within a global economic system. Deacon[19] writes "economic competition between countries maybe leading them to shed the economic costs of social protection in order to be more competitive (social dumping) unless there are .... global regulations in place that discourage this". Some of the forms that this dumping has taken are reduction in public expenditure on health and undermining of effective regulation of environmental pollution notably in the need-based world of which India is a part.

The result has been a long-term deterioration of our public health system including the capacity to prevent, control and treat communicable diseases. Within

this framework inadequate social welfare and public health systems are the main cause of drug resistance resulting from incomplete and inappropriate use of medication and unregulated sale of antibiotics. But more than this is the reality of the evolving world culture that propagates a seemingly rapid global culture of reform but which excludes populations without financial resources from say HIV triple therapy or regimens for treating MDR-TB or anti malarial medication[18].

The reigning logic of cost-effectiveness characterizes the 1999 World Health Report of the WHO. According to it "it does not make economic sense to try to provide comprehensive medical services for everyone". Typically treatment for MDR-TB is considered too expensive for resource poor settings[20]. Such analysis are flawed both technically and morally and rely on a "differential valuation of human life, for those who advocate such a policy, regardless of their nationality, would never accept such a death sentence themselves" (Institute of Medicine, 1997).

Like Richard Horton, we have to put the major share of failure at the door of our government, policy makers, national health infrastructures and market mechanisms that degenerate caring human beings to unfeeling machinations. The last answers why increase rates of patented basic drug prices haven risen from 5 to 67%[21], why our laboratories underreport positive TB smears by 80%, why poor quality or dangerous drug cocktails are prescribed for patients by private practitioners, why government deregulates drug policies, or why poor patients need to discontinue their AKT. Horton[22] calls it a "displacement of collective responsibility and turning away from the consequences of a globalizing world - thinking it fragmented into myriad pieces with their own fate, autonomy and responsibility".

In the event of deliberate misleading and the absence of caring and commitment by the government, industry or the affluent classes it is intriguing that Dr. Kochi of the WHO once again focusses on a $ 300 million endowment fund to buy TB medication in the stop-TB declaration[6]. He fails to qualify however whether these drugs will be made available to need-based countries once again through mega loans of The World Bank replenishing the cycle of poverty, destitution and disease. The situation for TB may in future mimic the HIV-endemic nations of Africa which are currently being "persuaded" to avail of U.S. loans for procurement of anti-HIV drugs from U.S. pharmaceutical companies[23].

It is now imperative to simultaneously also question the facile supposition that sufficient drugs or even new drugs will stem a disease for whose sufferers there is no caring. Drops in drug quality, mismanagement of supplies, inequitable pricing and the pressure of multi drug

induced resistance will continue to rear their head time and again the last with ever increasing virulence[8]. Perhaps Kochi adheres to Styblo's contention that whilst socio-economic development leads to an annual decrease in TB upto 4% per annum, effective chemotherapy can increase this rate to 14%[24]. But the operative word is "effective". Socio-economic conditions and the changing properties of germs now continuously ensure that drugs will become less and less effective. The post-antibiotic era for TB is beginning. We wish, it away only at our peril.

Epilogue

It is indeed convenient and easier to analyze the emergence of MDR-TB in India (and globally) in the sole context of a biomedical model or logistics of drug supplies. This stance suits international agencies and researchers who can then tinker with outcome projection models, deviate resources into research for new drugs (which a naive "Roll back malaria" programme advocates every 3 years!) and then rest with an easy conscience. The underlying pervasive common theme of poverty is paid lip service or delicately not mentioned at all. To admit in the present climate that a large group of adverse health conditions are basically the result of reductions in disposable income amongst the poor and admit that development policies have an unintended or intended consequence of exacerbating poverty, requires qualities of caring and a strong moral fibre: indeed it may even be expressed by a few that in the "larger benefits" of globalization, some outcomes such as marginalization are inevitable!

This paper does not reject completely the biomedical model. The initial discussion is focussed on drug action and its nuances but it does not end there. Its aim is to show that even within a narrow technical purview there are issues of caring, costs, poverty and misleading. Refusing steadfastly to recognize this, international funders harp only on drug-based solutions and research. Because the issues are complex, the causal linkage between consequences of adjustment policies and health status of the poor is difficult to formulate and gets bogged down in academic semantics, arguments and eventually convenient confusion[25]. It is hoped that the new strategy of policy-oriented monitoring of equity in health does not suffer the same fate. As Braveman[26] states "Better data and methods are needed to monitor equity, but in virtually any country ..... even the poorest nation with the most meager data ..... far more could be done now with existing data and simple methods".

Therefore any technical strategy needs to address the formidable national and international political obstacles to the achievement of health. Even tragedies such as MDR-TB have their uses in serving as models to highlight these obstacles.

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Section II

A. Civil Society Partnerships
B. Case Studies

6 The State and Civil Society: Meeting Health Needs, Reaching Equity

Shobha Raghuram
Manashi Ray

Introduction: Globalisation and Health

"There have been impressive successes in the health sphere from which other quality of life sectors can learn. But there is still much unfinished business. The right to health must be realised for the one or two billion people who do not yet enjoy it- and for the extra billions of people who will be added to the world's population over the coming decades. And this calls for both a significant shift in medical and other health services and for no less than a revolution in the culture and power structure of health care".

'Caring for the Future; Making the Next Decades Provide a Life Worth Living; Report of the Independent Commission on Population and Quality of Life', Oxford University Press, New York, 1996, pp. 210.

During the last decade the debate on globalisation has been as intense as the process itself. What has been of significance to those interested in development issues is the fact that some matters of serious human significance such as health have simply not received the attention that they should have. Further, the grammar of globalisation became as celebrated as the grammar of localisation became more and more invisibilised. The integration of national economies with global trade flows has been the central interest of nation states in their rapid

transition towards promoting growth-led economies. The discussion of safety-nets for vulnerable populations, further disabled in the reform processes has been the only area where there has been some research and investigations on the impact of the globalisation processes and the stabilisation measures within national economies. Field studies and other broader research analysis is showing that much is left to be done. Assuming that there is political will within national governments to address this set of problems it is clear that we have a huge agenda in front us. It is a glaring paradox today that while globalisation has been written and thought of as positively contributing to setting standards globally, it is clear that we are living through times when the divides have become even more stark and worrisome. Health has been a sector of silent neglect for several nation-states, receiving scant attention when it comes to financing research, institutional services, provision of care, affordability of medical supplies, and all related public health needs. Severe local imbalances and disparities mark this arena of human development concerns. If standards are of value to us it is clear that the exclusion of millions of people from being considered equal players in the acquisition of living standards, not to speak of all the various resolutions passed by the WHO and endorsed by many national governments as their own goals, makes the issue of standards a matter of double speak. The severe local and global imbalances in the enjoyment of health call for radical measures which may bring a greater equilibrium in the enjoyment of health.

In this paper we examine the health standards for the poor in India within the broader context of human development concerns during the last decade, with special emphasis on the role of the state and its commitment towards achieving 'health for all'. We also look at the factors that inhibited a nation from meeting this goal. We examine the policy implications of the present context of unmet needs and the confluence of variables that have prevented the poor from living in a state of well being. We underscore the need for reforms in the state services, the need to define the political economy of health and the issue of strong and continued public action for securing the right to health. This issue has taken on urgent overtones considering that with the growing failure of the state in many developing countries to meet all the health needs of the poor there has been an increasing reliance on the market forces/mechanisms to address welfare needs esp., health, education, housing and shelter, and food security of the vulnerable. Has the experience of minimising the role of the state during the reform period been beneficial to the poor? What was the response of civil society in issues of public health and in auditing the accountability of the state? Were the health initiatives supported by the state in the 90s in accordance with the epidemiological transition in India? The question of whether universal care can be

afforded and managed by the public sector alone is important. So also it is necessary to explore the issue of appropriate fiscal, human resources and social systems that need to be developed to sustain the process of guaranteeing equity. How is the decentralising of health policy to be achieved? How can information dissemination be accelerated to enable people to make the crucial transition to protecting their own health rights more effectively?

The central concern of our work is to contextualise health and the guaranteeing of good health in the larger field of social development efforts in the country. The discussion on globalisation, equity and health should not be laboured under the same rubric of growth and liberalisation. The state may indeed have performed too little in the areas of basic needs. We in fact suggest that what is required is the maximisation of the state in providing sufficient conditions for basic needs provisions. Sen (1996), when writing about intrinsic value and human capabilities, in fact drew the attention of policy makers to the fact that the excessive concentration on issues of liberalisation and market led changes has detracted from the fact that the social sector areas have suffered from too little role of government and not the other way around.

"The elimination of ignorance, of illiteracy, of remedial poverty, of preventable disease, and of needless inequalities in opportunities must be seen as objectives that are valued for their own sake. They expand the freedom to lead the lives we have reason to value, and these elementary capabilities are of importance on their own. While they can and do contribute to economic growth and to other usual measures of economic performance, their value does not lie only in these instrumental contributions. Economic growth is valuable precisely because it assists to ameliorate deprivation and to improve the capabilities and the quality of life of ordinary people (Sen and Dreze, 1996 pp.5).

The lessons of economic and social growth across the world over the last few decades have forcefully drawn attention to the instrumental importance of education, health and other features of the quality of human life in generating fast and shared economic growth. (Dreze and Sen, 1996 pp.28).

Sen (1996) argues that the radicalism that is required cannot just be met by removing constraints of deregulation and reform. It has to include the duties of a responsible state in creating social opportunities that are valuable in themselves and which also assist in the process of economic development.

"Hence, the problem with the economic reforms currently under way is not that they are not needed, nor that they are over exacting, but that they are basically inadequate and unbalanced. In adopting the lessons from newly industrialised countries we must take note of the totality of the experience in making them so successful. This would include taking a fuller view of the government's role. Therefore, the fundamental changes that are needed in India cannot be met by only moderate reforms that focuses on the

negative activities of the government, neglecting the vast potential the state has in performing a positive functions in bringing social opportunities within the reach of all. To the foundational lacuna of neglecting the scrutiny of the basic ends is, thus, added the more immediate gap of ignoring the examination of some powerful means that help us to achieve those ends. In fact, it can be argued that achievement of even the limited objectives of the current reforms will depend crucially on conscious and organised pursuit of the social means on which economic performance and results are frequently conditional." (Sen and Dreze 1996 p.4).

National governments need to commit in the globalisation process the means they will choose to create optimal conditions for equality as a necessary end. The means must include the critical values of democracy, equality and people's freedom to live with dignity. It is clear that the gruelling data of existing poverty in the country has completely influenced the profile of ill health. Chen and Dasgupta (1996), contend that health and poverty may be presumed to share a 'synergistic and bi-directional relationship, wherein poverty exacerbates ill health and ill health diminishes labour productivity'. They underscore that although, the close linkage between ill health and economic poverty is generally accepted, surprisingly little evidence has been generated on the power of this relationship. Data on this relationship at the individual and household levels are, unfortunately, extremely thin.

"Much research by economists has been directed at defining poverty or estimating its incidence. Less effort has been invested in elucidating the health dimensions of economic poverty; indeed in India the literature on these relationships is virtually lacking. There is evidence, of course, that economic poverty leads to low food consumption and besides, compromises some powerful determinants of health, such as housing, and utilisation of education and medical services. However, we know much less about the reverse direction in the health-poverty relationship. The impact of ill health on economic production at the individual, household and national levels is poorly understood.[1] *Few studies exit on the economic impact of illness at the national level. This vacuum is perhaps one reason why health investments are often considered by economists as entirely 'consumption, and why economic planners often downgrade the significance of health investments in national resource allocation. Health expenditures have yet to be recognised as investment in human capital. ". (Chen and Dasgupta, 1996. p.1)*

The political economy of health will in the coming years be a critical area of work as poverty, health and development closely interconnect influencing the overall arena of social equality.

1 There are isolated studies, for example, of higher physical work output and productivity-generated wages after interventions that improve the health status of workers, one commonly cited study being the wage gains of Indonesia rubber tappers after treatment for iron deficiency anaemia. Disease and nutritional deprivation retard child growth and development, demonstrably affecting subsequent adult work performance.

I. *Role of State and Equity*

The last fifty-one years of development history have clearly shown the limits to policy, and the greatest need for consolidated social and political action taking place at the most micro- levels and at the same time to critically evaluate national governments which in the larger sphere of state role advocate policies which undermine human development. Historically, the government after independence was compelled[2] by the sheer weight of the number of poor in unequal health circumstances to make many committed pronouncements pertaining to improving the lot of the vulnerable in the Constitution, the Five Year Plans and in the party election manifestos. (See Raghuram, 1998). Banerjee (1998) gives importance to the sheer compulsions of the situations that had enabled the masses to wrest these concessions from the new government. However, gradually the actions that followed these pronouncements became too inadequate to meet even the basic needs of the people. The report of the Voluntary Health Association of India (VHAI) sponsored **Independent Commission on Health (1997)** produced data to highlight the fact that this neglect by the state has further deteriorated the situation particularly over the past three decades. There has been no dearth of policy documents. Take e.g. the 1978 "Health for All" Declaration at Alma-Ata Kazakhstan, which received a full-fledged commitment from the Indian government: The document called for a convergence of trends in thinking in relation to health, health care and development. This Declaration was important in proposing a broad and consistent philosophy towards a strategy secured in the PHC approach. It outlined the necessary shifts in strategic thinking and planning–renewing relationships between health service, professionals and members of the community. Of central importance was equity as a component to health. It called on national governments to recognise the need for community participation in decision making and the need for a multi-sectoral approach to health problems. The need to ensure the adoption and use of

2 According to Banerji (1998), the interplay of the political forces have shaped health and health services during the past two centuries. The British colonial conquest saw further worsening of the exploitation of the masses. The colonial rule also ensured the superimposition of the Western medical practices on the pre-existing practices of the people which they have been following for coping with the health problems. In the colonial context, along with the erosion of whatever existing practises of coping the poor had, the profusion of health problems that emerged from the radical changes had a devastating impact on the health status of the people. These changes in the equilibrium between the host-environment-causative agents,had an impact especially on the poor which formed as much as 80% of the population then.

appropriate techniques made the document a flexible instrument in the hands of policy makers. Equity was defined as equal health, meaning

- *Equal access to care*
- *Equal utilisation of health care*
- *Equal access to health care according to need.*

An examination of the status of health indicates that India is doing well in some respects, but not so well compared to many developing countries. Though mortality levels continue their long-term decline, they remain high, along with undernutrition and morbidity levels. Most of sub-Saharan Africa and South Asia have shown more modest achievements, with life expectancies remaining below 60 years in 1998. In some states of India, mortality levels are comparable to the poorest regions of sub-Saharan Africa countries. This is surprising, since India has far greater resources in terms of finances and trained manpower, and better developmental infrastructure in the form of transport, communication, electricity and water supply than most sub-Saharan African countries.

Moreover, there exist marked disparities between groups within the regions of India, which make some sections of the population highly vulnerable. In addition to the rural-urban divide, the caste, class and gender disparities in health persist, giving rise to a situation in which different pockets of population within the same country portray differing health status. Thus, very little disaggregated information is available on the burden of illness and nutrition status of the Indian population. Further, the health sector has largely been overlooked in the context of larger development processes and policies. This has resulted in a skewed approach to health without the complimentary aspects of development like clean water, sanitation, elevation of poverty, effective demand for food and nutrition a greater public awareness and participation in health, compulsory primary education, all of which are critical components of a genuine health and development strategy.

For India as a whole the crude death rates have declined since 1920 while crude birth rates began to decline only after 1940. The resulting gap between fertility and mortality has resulted in a rapid growth of India's population over the past half century. India therefore remains midstream in its demographic transition, and the future pace in the decline in fertility and mortality is not certain. Dasgupta, Chen and Krishnan (1996) contend that there is no reliable data on the causes of death in India. But models developed from data of other populations could be used to estimate probable shifts

in the causes of death patterns in India. There too India may be assumed to be in the midst of epidemiological transition where in the chronic and degenerative diseases are increasingly displacing the health hazards of malnutrition infection and reproduction. However, these shifts are now being complicated by the onslaught of fresh, unanticipated health threats including HIV/AIDS epidemics, environmental health hazards and rising behavioural pathologies like substance abuse, violence and accidents. It is believed that multiple factors are responsible in these shifts, which includes greying of the population age structure, impact of health interventions such as immunisations and medical care and changing lifestyles and risk factors affecting disease incidence.

In fact, health policy analysts are right in pointing out that India is experiencing all three stages of health transition simultaneously: Health problems associated with underdevelopment (among the poor and the disadvantaged), the emergence of diseases of affluence (specially among the urban middle class), and new environmental and behavioural threats (among all population groups). Therefore, little is known about the extent of these transitions which are creating 'polarisation' of health between different groups within the same country, in which varying groups may be experiencing entirely disparate health worlds. Even less is known about the specific impact of globalisation during this multiple transitional phase on the different groups. Understanding these transitions and their differing impact on the population is important for public action, not only for designing appropriate policy but also for measuring the benefits of competing health investments on different groups of population.

a. Social Development and Health during the Reform years (91-92 onwards)

Indicators of social development suggest that India has made considerable progress in the last five decades. For instance, life expectancy at birth has doubled from 32 years at the time of independence to 62 years in 1995, infant mortality rates have halved and the literacy rates have trebled. There is also evidence that health care, housing and education are better. The proportion of the population that has access to electricity, drinking water and sanitation facilities is also notably higher.

Table No. 1

Basic Indicators of Human Development						
Year	Life Expectancy at birth (Years)	Literacy rate @ (percent)	Birth rate*	Death rate*	Infant Mortality rate*	Per capita NNP at 1980-81prices*(Rs)
			(Per thousand)			
1951	32.1	18.3	39.9	27.4	146	1127
1961	41.3	28.3	41.7	22.8	146	1350
1871	45.6	34.5	36.9	14.9	129	1520
1981	50.4	43.6	33.9	12.5	110	1630
1982	NA	NA	33.8	11.9	105	1693
1983	55.4	NA	33.7	11.9	105	1691
1984	NA	NA	33.9	12.6	104	1790
1985	NA	NA	32.9	11.8	97	1811
1986	NA	NA	32.6	11.1	96	1841
1987	NA	NA	32.2	10.9	95	1870
1988	57.7	NA	31.5	11.0	94	1901
1989	58.3	NA	30.6	10.3	91	2059
1990	58.7	NA	30.2	9.7	80	2157
1991	59.4	52.2	29.5	9.8	80	2222
1992#	60.8	NA	29.2	10.1	79	2175
1993$	NA	NA	28.7	9.3	74	2243
1994	NA	NA	28.7	9.3	74	2334
1995	NA	NA	28.3	9.0	74	2608@@
1996P	62.4	NA	27.4	8.9	72	2761@@

NA - Not Available, P-Provisional NNP - Net National Product

Based on the extrapolated values of the Standing Committee of Experts on Population Projection, centered at June 1992. $ Life Expectancy at birth for 1989-93 (Abridged) was 59.4.+ Data for 1951, 1961, 1971 and 1981 relate to the decades 1941-50, 1951-60, 1961-70 and 1971-80 respectively, centered at mid-point of the decade I.e. 1946, 1956, 1966 and 1976. For 1983, data relate to 1981-85, centered at 1983. The estimates centered at 1988, 1989, 1990 and 1991 refer to the periods 1986-90, 1987-91, 1988-92 and 1989-93. For 1996, data relate to the period 1996-2001 and is based on the report of the Technical Group on Population Projections constituted by the Planning Commission, August 1996.@ Data for 1951, 1961 and 1971 relate to population aged 5 years and above and those for 1981 and 1991 relate to population aged 7 years and above. Data exclude Assam for 1981 and Jammu and Kashmir for 1991 onwards.* Data for 1951, 1961, relate to the decades 1941-50, 1951-60 respectively and the estimates for 1971 and 1981 onwards are based on the Sample Registration System (SRS). BRs, DRs and IMRs for 1991 and onwards exclude J&K. (For 1996 excluded Nagaland also).

** Relate to financial years 1950-51, 1960-61 and so on.

@@ Quick Estimates

Source: (I) Registrar General & Census Commissioner of India

(II) Central Statistical Organisation. Reference: Economic Survey 1997-98; pp.139.

Nonetheless, much remains to be done. By international standards, India fares poorly among developing nations. Almost half the population is still illiterate. Infant mortality rates are still inordinately high and enrolment ratios at primary school very low. **Further the availability of or access to social infrastructure is uneven between social groups, economic classes and geographical regions.** The scheduled classes and tribes, in particular and the poor, in general, are being adversely affected. Social infrastructure is poor in absolute terms.

During the 1980s there was a significant increase in the resources provided by the government for expenditure on social sectors. Unfortunately, this has not continued when liberalisation began. During the period from 1989-90 to 1993-94, the budgetary allocations for the social sectors by the central government stagnated in real terms and remained unchanged as a proportion of GDP. This trend was also reflected in the budgetary provisions made by the state government for the social sectors. As a result, for the centre and the states, taken together, the expenditure on social sectors stagnated in the range of 6% of GDP (Bhaduri and Nayyar 1996).

Further, Quadir (1997) states that when health and family planning are put together, **the investment in Medical and Public Health has declined from 2% in the Sixth Five Year Plan to 1.75% in the Eighth Five Year Plan, despite the fact that the Eighth Plan claims human development to be its ultimate goal.**

Table No. 2

Central Plan Outlay for Major Schemes of Social Sectors (Rupees In Crores)						
Ministry/ Dept./ Scheme	90-91	93-94	94-95	95-96	96-97	97-98
	(Actual)	(Actual)	(Actual)	(Actual)	(Actual)	(Actual)
Health	255	402	599	649	818	918
Family Welfare	**785**	**1523**	**1430**	**1506**	**1547**	**1829**
Women & Child						
Development	313	573	662	821	847	1026
Ofwhich ICDS	258	474	537	669	682	834

Source: Economic Survey, 1997-98, pp.138

b. *Central Plan Outlay for Major Schemes of Social Sector*

The SAP initiative in mid 1991 led to expenditure compression in Union Government finances in the first 2 years. The situation improved in subsequent years with a step up in the allocation to rural development, education and health at the level of Union Government since 92-93, although the emphasis has been on different items in different years. The cuts were severe in the first two years of the reform process, followed by some restoration in the next four years. In the opinion of Sengupta (1996), while there was a fall, in real terms, during 1990-91 and 1993-94, of expenditure on health care for both centre and the state, it was much more pronounced in the case of the state.[3] The fall in the expenditure by state governments is a direct consequence of the reforms. States, in this period, were starved of funds due to lower transfer as well as due to yield from shareable taxes falling from 5.6% of the GDP in 1990-91 to 5.1% in 1993-94. This shortage on the resources of states was distributed in a fairly secular fashion over expenditure incurred under all development heads. The greatest casualty was health care, as the share of the states constitutes a major (approxi-mately 75%) portion of expendi-ture. A similar kind of squeeze in resource allocation was felt in all programs, primarily financed by the states, including water supply and sanitation. As opposed to this, the almost exclusively centrally funded family planning program fared much better even in the worst resource crunch years.

Table No. 3

Outlays on Rural and Urban Water Supply and Sanitation Programmes in Central Budget : 1990-91 to 1995-96 (Rupees Billion)						
	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96*
Rural water supply	4.03	6.38	4.6	7.38	8.1	11.1
Rural sanitation	0.18	0.04	0.2	0.32	0.6	0.6
Urban water supply	0.25	0.33	0.23	0.41	1.06	0.65
and sanitation						

* Budgeted Estimate; all others are revised estimates

Source: Guhan (1995) Reference: Ranade and Mahendra Dev (1997) in "India Development Report".

3 During the first few years of SAP the Central Government grant to the states on the disease programmes fell from 25.2% in 1991-92 to 18.5% in 92-93. This gap was partly restored through the WB loan., with priority to Tuberculosis, blindness and HIV/AIDS with conditionalities in terms of what it should be spent on and repayment. This was reflected in the Union Budget of 1993-94, which tried to restore some of these losses. The poor states suffered because of this decline in Central grants, which resulted in an outbreak of epidemics in states of Orissa, Bihar and Rajasthan. As result of this cut some states had to borrow to tide over the financial crises, but this could help them only temporarily.

Therefore in the post reform years, health does not emerge as a priority in social sector planning. The ideological underpinnings associated with the reforms package legitimises the state's withdrawal from infrastructural areas, including infrastructure in social sector. Health care is no more perceived as a function of the state[4]. This could be considered the singular contribution of the reforms era. In the process, the supposed inability of the state to sustain funding of medical care has gained acceptance. This legitimacy of the role of the private sector in health care is now openly exhibited, as is the concept of 'user fee' for government run hospitals. Quadir (1997), remarks that the strategy of "Health for All" which has been re-oriented towards "Health for under privileged" in Economic Survey, 1996-97, in reality might ensure the exclusion of the poor and the under privileged from accessing the public sector services as there are no mechanisms to identify and debar the "not so underprivileged".

The logic of the greater role of the free market has allowed for the introduction of an International Development Assistance (IDA) aided State Health Systems Development Project in three major states of Karnataka, West Bengal and Punjab. The five year project involves a loan of $342.2 million (Rs. 540 crores) from the IDA[5]. The *projects will be important for tracking considering that it will be the first systematic attempt at putting into practice the twin prescription of involving the private sector (NGO) in primary health care and of levying 'user fee' at government run health facilities.*

The objectives of IDA project include (i) upgrading of PHCs and improving access in select areas and by vulnerable sections (ii) upgrading community, sub-divisional and district hospital (iii) upgrading effectiveness of clinical and support services (iv) improving referral mechanisms (v) strengthening management and implementation capacity of institutions and (vi) developing surveillance capacity for major communicable diseases.

The most notable feature of the project is that these objectives are linked to levying of user fees and contracting out chunks of the primary health care network to NGOs and private institutions. The project seeks to increase collection of user fees to 15-20% of total incurring costs from the

4 Interestingly, in India the public sector is a major contributor only in the case of hospital care and in preventive and promotive public health measures. Private sector accounts for 80% of health care expenditure and has always had a large presence in private medical sector, especially for non-hospital care.

5 These projects in health care are attempts at implementing many of the World Bank's prescriptions for health care in developing countries-levying of user fees-a stated World Bank position since 1987-involvement of the private sector, targeting of services, reduction in manpower, etc. In the coming years the projects will be closely monitored with regard to their ability to qualitatively change the direction of health care funding and management in the country. (Sengupta, 1996 and Duggal, 1997).

present level of less than 4%. User fees are to be charged on those who do not qualify under a predetermined exclusion criterion in each state (Sengupta, 1996, Purohit and Mohan, 1996 and Duggal, 1997). Nevertheless Quadir (1997) states that experience, the world over, has demonstrated that user fees do not lead to accumulation of capital which can be considered sufficient as an investment for ensuring maintenance of services. They also show that it is not possible to develop methods of identification of income categories. In fact expenditure incurred on creating systems of recording and collecting fees carry high costs and make the whole exercise futile.

In his critique of the IDA project, Kumar (Rao, et al, 1995) questions the notion of equity, which does not merely fall within the economic domain but raises certain ethical and philosophical issues. Equity becomes important because of the implicit understanding that illness is beyond an individual's control. Consequently, it follows that there should be equal treatment for equal needs and distribution of health care must be independent of considerations of class, gender and other forms of political and economic exploitation. To cite the author "in defining equal treatment for equal needs, it is important to focus upon equality of opportunities and access, rather than equality of treatment. The underlying assumption in equality of access and the pricing of health care is that everyone can pay the same price. What it does not take into account is that the poor may have to make a bigger sacrifice in order to pay for the same service."

The greatest killers in the post reform period continue to be the still familiar sounding diseases like Cholera, T.B., Malaria, Kala Azar and worst of all hunger. In case of Malaria, the incidence figures have been pegged down to roughly 2 million cases every year but what is worrisome is the steady rise in the deaths due to malaria in the last few years. In some tribal pockets, 50% of people test positive for malaria. In April 1995 there was a outbreak of Falciparum Malaria in Assam resulting in the loss of many lives. A large number of cases of malaria were also reported from Bihar, M.P, Orissa, West Bengal and other states. Malaria epidemics are known to be associated with economic depression and the emergence of the pesticide resistance to vector and drug resistance to the malarial parasite in many parts has made the situation more complicated.

Given the situation, the 1992 budget had seen one quarter of the planned Central Health Budget being allocated for HIV/AIDS, while the budget for Malaria control had been decreased by 43%. Although, the central plan outlays have been enhanced substantially for control of major diseases like malaria, tuberculosis and HIV/AIDS, when these investments are compared as a proportion of the total

outlay for the year 1996-97 in health, the real expansion has only been in the Programme for HIV/AIDS control. From a 12.38% of the total investment in health, it has been raised to 17%. In absolute terms, the increase is from Rs.79.8 crores to Rs.141 crores. In reference to tuberculosis (TB), the absolute increase from Rs.50 crores in 1995-96 to Rs.65 crores has actually meant a shift of 7.6% to 7.9%. Malaria fares still worse. There is an absolute rise from Rs.119 crores to Rs.145 crores, in terms of proportion there is a decline from 18.46% to 17.7%.

Table No. 4

Plan Outlay (Rupees In Crores)												
Disease	1990-91		1991-92		1992-93		1993-94		1994-95		1995-96.	
Nos.	%	Nos.	%		Nos.	%	Nos.	%	Nos.	%	Nos.	%
Malaria	73.5	27.79	83.00	28.23	77.00	26.18	90.00	19.15	90.00	15.93	119.00	18.56
T.B	13.93	5.26	16.00	5.44	29.00	9.86	35.00	7.45	46.00	8.14	50.00	7.76
Leprosy	23.20	8.78	24.00	8.16	35.00	11.90	35.00	7 .45	94.00	16.64	80.00	12.41
Kala	-	-	-	-	-	-	-	-	20.00	3.54	20.00	3.10
Azar												-
HIV/												
AIDS	-	-	-	-	63.99	21.75	66.24	14.09	72.00	12.74	79.80	12.38
STD	-	-	-	-	0.45	0.15	0.50	0.11	0.25	0.04	0.18	0.03
Total Health	264.53	28.16	294.00	28.19	294.15	22.73	470.00	27.01	565.00	28.32	644.57	28.96
Total Family Planning	674.95	71.84	748.95	71.81	1000.00	79.27	1270.00	72.99	1430.00	71.68	1581.00	71.04
Total	939.48		1042.95		1294.15		1740.00		1995.00		2225.57	

Reference: Alternative Economic Survey, 1997
Source: Annual Budget of GOI
Plan outlays for different years in crores of rupees (indicated in the Nos. columns for various diseases; the outlay for family planning is also shown. The percentage columns give the percentage of the total outlay in the given year.

These trends in investment in communicable diseases suggest clearly that during the 90s, the State had reduced its efforts in controlling Malaria and had laid more emphasis in the control of TB and HIV/AIDS (Quadir, 1997).

During the decade of the 90s, India's health policies, and programmes, and the pattern of high allocation changed dramatically. Some of these changes are

not in keeping with the epidemiological[6] and social requirements of the country. With the international and bilateral funding of some health programmes there was a gross distortion of priorities in disease control and health development. It is given to understand that there is a linkage between Structural Adjustment Programme (SAP) and increased spending by donor agencies on specific programmes, in order to promote certain directives, not necessarily in consonance with local needs.

c. *Multilateral and Bilateral Funding*

Although external assistance amounts for only 1.6% of the total expenditure of India, this small contribution plays a crucial role in capital investment, strategic planning and research in health. When analysed, distinct patterns can be identified regarding the volume of funds, the main funding agencies both multilateral and bilateral, the type of programmes being funded and the period of funding. There was a predominant departure in funding patterns from the mid 80s onwards[7] Bilateral commitments decreased and multilateral agencies (like the World Bank, IMF, and ADB) became major financiers of the health programme in developing countries. This entry of international agencies signalled an attempt to dictate development policies programmes and plans of the country. It has also been observed that the increasing role of international financial organisation in health and development policies has further contributed towards aggravating the inequities in health status. World Bank (WB) is the most significant multilateral funding agency in India. Its commitment at present is almost 65% of the total foreign assistance to the health sector.

In 1981, WB funding for health was US$ 33 million, rising to US$ 263 million in 1990. Before SAP, the WB funding was usually given as grants. During the SAP period soft loans were given for various health programmes. Grants could directly subsidise the service whereas in soft loans, such a means of deficit financing implied later repayments. In such a scenario, India can exercise little its right of setting its own priorities and has to accept the conditionalities. While HIV/AIDS get majority funding from the WB, other major

6 India's epidemiological profile suggests that greater emphasis on prevention and control of communicable diseases will have had the maximum impact on improving health by reducing exposure to disease. Preventive measures are currently largely provided out of an institutional setting of qualified doctors and their staff, i.e. the institutional setting of curative services.

7 During the 70s and until mid 80s foreign funding in health in India was largely through bilateral agencies like DANIDA, SIDA, ODA now DFID, NORAD and USAID. Of the total external aid in health to the tune of US$ 859 million in the 70s, a major portion was from the USA government (57.4%) followed by UNICEF (15.6%) , the WB (10.7%) and WHO (6.3%).

diseases like Tuberculosis, Diarrhoea and Malaria which cause high morbidity and mortality get neglected.

The vertical intervention programme of the WB has to be seen within the context of SAP, where investments in social sectors is perceived as an important handle for protecting the vulnerable sections from the impact of SAP and market driven policies. The WB clearly articulated the need for investment to elevate the impact of adjustment in this area of social service. It emphasised on controlling and preventing communicable diseases and building health infrastructure. The WB package on communicable disease focuses mainly on HIV/AIDS, Tuberculosis, Malaria and blindness. It is important to note that between 90-93 the WB funding for HIV/AIDS went up from Rs.400 lakhs to Rs.5800 lakhs while the budget for Malaria declined by 38% during the same period. Before the decade of '90s, the WB funding was concentrated on population projects and nutrition programmes.

In 1972-73, external assistance under the family planning programme comprised of 9.22% of total expenditure of Rs.7,975 lakhs. In 1989-90, this share rose to 27.64 % of the total expenditure of Rs.78,140 lakhs. With reference to the Area Project for Family Welfare for the period 1980-2001, of the total Rs.1,812 lakhs, the World Bank has committed Rs.1,558 lakhs (86%), as against other bilateral agencies which have together contributed Rs.254 lakhs (14%). Therefore, even if the volume of assistance might have been small, donor agencies have been able to exercise their influence on the government's health sector policies considerably (VHAI, 1997).

VHAI (1997) states that "there has been a perceptible shift in the pattern of external funding between 1985 and 1995. For instance in malaria care, bilateral funding during 1985-89 was Rs.1,351 lakhs. There was no funding during 90-95, whereas multilateral agencies contributed Rs.840 lakhs in 1990-95. In Tuberculosis care, bilateral agencies committed Rs.56,229 lakhs for the period 1985-89 and only Rs.140 lakhs for 1990-91, whereas multilateral funding for 1990-95 was Rs.84,121 lakhs" (pp.41). The World Bank committed Rs.31, 370 lakhs for HIV/AIDS during the period 1990-94, while bilateral agencies did not have any separate funding for HIV/AIDS.

d. *Nature of Funding and Policy Shifts*

In addition there are specific guidelines of how the funds are to be spent. A major portion of the funding by bilateral agencies for communicable disease and family welfare programmes is in the form of assistance for equipment, supplies and training, drugs and consultancy. The funding pattern is disease specific and state specific. Until the 90s, the focus was on Malaria and Leprosy. During the 90s

blindness control, Tuberculosis and HIV/AIDS gained prominence.

The current 'Revised National Tuberculosis Programme' supported by WB, which emphasises treatment through short course chemotherapy based on multi drug therapy regiment under direct supervision is a clear departure from the earlier National Tuberculosis, which was integrated into the general health service as a non-vertical programme. Another example is that of HIV/AIDS, which is still not a major cause of mortality in India as compared to other diseases. Excessive funding in this case has clearly influenced the direction of health policy of India. Therefore, it becomes evident from the above fact, firstly, foreign assistance for communicable diseases might not reflect the epidemiological priorities of the country and secondly very often the content of the programme also gets influenced by foreign donors.

In family welfare, the emphasis on infrastructure has been mainly on sub centres. But the question is how will the states run these centres once the external funding cease? These issues highlight the critical gaps in health sector planning as the government will have to cut back on other sub sectors of health in order to sustain programmes like family welfare and the eradication of communicable diseases. On the whole, after the initiation of economic reforms in the 90s, the sustainability, health priorities and the future of public health programmes have been greatly influenced by external assistance and have not been pro-poor, neither pro-people.

During the reform years, the Family Welfare Program continued to promote the small family norm and reproductive and child health, through free and voluntary choice. A target free approach with emphases on Maternal and Infant Mortality Prevention and on "Safe Motherhood" and mid-day meals for school children were the notable features[8]. The Eighth Plan document recognises that the goal of reaching Net Reproduction Rate of Unity (NRR-1) might now be achieved by 2011–2016 instead of 2000 as laid down in the National Health Policy, 1983. During the 90s, Government has been able to achieve decline in Fertility Rate from 4.5 in 1981 to 3.5 in 1994. The Crude Birth Rate (CBR) has decreased from 33.9 per thousand population in 1981 to 27.4 in 1996

8 During the last two years of the Eighth five-year Plan, certain policies underlying the family welfare programmes have been reviewed and re-organised. The first pragmatic initiative has been re-organisation of the Child Survival and Safe Motherhood and related programmes into the Reproductive and Child Health (RCH) package of programmes. A provision of Rs.450 crores has been made in 1997-98 (RE) for RCH scheme. The second initiative has been to abolish targets for individual contraceptives, though the overall population control and health related goals remain. With the replacement of the system of setting targets from the top, the emphasis on quality has been strengthened (Economic Survey 19-98).

as per the provisional estimates of the Sample Registration System (SRS). The crude Death Rate (CDR) has also declined from 12.5 to 8.9 per thousand population over the same period, refer Table 1 Consequently, the rate of growth of population declined to 1.85% in 1996 (Economic Survey, 97-98). There has also been a sustained criticism (Raghuram 1998) regarding the overzealous effort at "empowering women", which begins and ends with their freedom to choose from a wide range of contraceptives. That these may be harmful or dangerous to her health is immaterial, for it is also the right of "free", markets to give or not to give correct information to consumers. Besides, in the absence of regulatory mechanisms in the fast expanding private market in Health and Family Planning and women – centered Family Planning strategy, women may become not only targets for the sale of contraceptives banned elsewhere, but also part of "research" efforts which they are not fully cognisant of.

The health sector during the reform years also witnessed the New Drug Policy in 1994 and subsequently the new Drug Price Control Order (DPCO) in 1995. In the new policy the government has granted major concession to the industry in terms of reduced price and production controls. This includes slashing down of the number of drugs under price control and increase in profits allowed to drug manufacturers. This has led to widespread and spiraling increase in drug prices and also meant that drug MNCs are now treated on par with Indian companies and can enjoy the same facilities. According to Shiva (1996), as the drug companies have built a market for their drugs through their extensive marketing network, the consumers have little or no choice in such a 'rigged' market. The consumer is targeted ceaselessly by the biased and irrational promotion of drugs by drug companies. There is an estimated 60,000 to 80,000 brands of various drugs available in the Indian market. In this situation the task of an already over stretched drug Control Authority becomes impossible to manage.

Taking into consideration all the issues it is difficult to assess if and the extent to which the reforms have had an adverse affect on health in the 1990s. However, it can be postulated that because of considerable decline in the public expenditure in the first few years of the reforms, there might have been adverse impact on the overall human development indicators. The assessment of the reform policies does not provide any positive signals within the health sector, as yet. Nonetheless, extreme caution need to be practiced to prevent the rolling back of many gains of previous decades, however insubstantial they may have been in the area of health. Yet, an achievement of even the limited objective of the current economic reforms will depend crucially on conscious and organised pursuit of these social issues on which economic performance and results are frequently

conditional, as amply evident from the success of East Asian economies of Singapore, Korea and Malaysia, who have along with market oriented policies did not neglect the critical issues of human development, especially education and health.

II. Health Security and the Poor: A Matter of Responsibility?

It is clear that the state as the primary and critical actor in ensuring equity urgently requires the consideration of an overall plan which can strategically strengthen the sector of health in the **overall plans of development and poverty eradication.** The financing of poverty alleviation programmes as well as social sector services requires a comprehensive effort both on the field and in the budget exercises. Health policy will increasingly need to be designed keeping in mind **both a national and local agenda.** Resource allocation, manpower policies, the degree to which health services are to be made available and accessible to the population, choice of technology etc need to be perceived and executed with equity as a principal and overriding determinant. Market considerations have often flawed an overall social justice agenda. The wider canvas of human security is the basis for the serious management of health deliveries.

Historically, although India's development policy since Independence has indeed been concerned with equity, the most pressing concern was of course with raising the rate of economic growth in the country. It was felt that India needed first and foremost to develop a strong industrial base while also raising agricultural output. As a consequence, Indian development strategy emphasised planning of commodity sectors to the detriment of planning of social sectors. The health outcomes of the country 50 years later clearly reflect these shortcomings in the development strategy.

The primary objective of the National Health Policy (NHP) which was adopted in 1983 was to attain the goal of **Health for All** by 2000 A.D by establishing an effective and efficient health care system for all citizens in particular vulnerable groups like women, children and underprivileged. The creation of an infrastructure for primary health care was emphatically stressed in the NHP. Other major priority areas were: close coordination of health related services and activities like drinking water supply, sanitation and nutrition; the active involvement and participation of voluntary organisations and provision of essential drugs and vaccines. In addition, qualitative improvement in the family welfare services and provision of adequate training and medical research aimed at the common health problems of the people. (GOI 1983) Hence, the 80s witnessed massive infrastructure expansion and programmes for providing family health care facilities to achieve the target of one primary health centre (PHC) for 30,000

people and one sub centre (SC) per 5000 people in the plains and one PHC for 20,000 people and one SC for 3000 people in the tribal and hilly areas. This target was more or less attained in almost all the states.

a. Infrastructure

However, in spite of the vast expansion in infrastructure it was grossly under-utilised because of poor facilities, inadequate supplies, insufficient effective person hours, the lacking of proper monitoring and evaluating mechanisms, poor managerial skills among doctors etc. Further, the system failed to work because of the mismatch between training and the work allocated to health workers, non-availability of suitable accommodation for the health team, inadequate transport facilities and unbalanced distribution of work time for various activities. In fact, number of studies have highlighted that family planning and more recently immunization receive a disproportionately large share of the health workers effective work time (IIM 1985, Gupta and Gupta 1986, Duggal and Amin 1997 and 1992 NSS 1987, NTI 1988, ICMR 1989, NIRD 1989, ICMR 1990, IIM 1991, NCAER 1992 in VHAI 1997). Quadir (1997) states that government's concern for an integrated approach to health planning for the underprivileged is unconvincing, as there is no mention of doctors, dispensaries and hospitals from 1993 onwards, as shown in the Table 5. There is no evidence that reveals efforts at strengthening the links between district hospitals and community health centres at the village level, and district hospitals and medical colleges at the city level. Consequently, if the middle level hospital system does not provide the support to basic institutions and is not supported in turn by tertiary care institutions, the delivery of Primary Health Care is bound to be differential and incapacitated in its preventive endeavours. The result is a hi-tech, super specialisation based service in rural areas with no supportive inputs for National Disease Control Programmes. By opening up public institutions to forces of privatization, they in effect are being asked to close their door to the poor. Their working as referral institutions is jeopardised as their services are linked to paying capacities.

Another serious flaw of the 1983 Health Policy has been the minimal community participation although decentralisation has taken place to some extent. A bureaucratic approach, insensitive to recognising and involving people's organisation in the

Table No. 5

Expansion of Health Services											
Item	1951	1961	1971	1981	1991	1992	1993	1994	1995	1996	1997
Medical Colleges** Centre§	28*	60	98	111	128	146	146	NA	NA	NA	NA
Hospitals**	2694	3094	3862	6804	11174	13692	NA	NA	NA	NA	NA
Dispensaries**	6515	9406	12180	16751	27431	27403	NA	NA	NA	NA	NA
Community Health Centre§	0	0	0	217	2071	2186	2289	2321	2385	2572	2619
Primary Health	725	2565	5112	5740	20450	20701	21030	21206	21536	21917	22002
Sub-Centre§	-	-	28489	51405	130984	131370	131384	131586	131795	134931	136324
Hospital Beds (all types)	117178	230000	348655	569495	834650	NA	NA	NA	NA	NA	NA
Doctors**	61840	83756	151129	268712	394068	410875	NA	NA	NA	NA	NA
Dentists**	3290	3582	5512	8648	10751	11300	19523	21720	23953	NA	NA
Nurses**	16550	35584	80620	154280	340208	385410	449351	512595	NA	565696	NA

NA-Not Available, *Pertains to 1950, **As on Dec.31, § As on March 31
Source: Ministry of Health and Family Welfare
Reference: Economic Survey 1996-97 and 1997-98.

implementation of the family welfare programmes in the country, forced the continuation of the use of private health services. Wherever public facilities for medical care are used, urban hospitals are preferred and this has much to do with the popular misconception as with the poor services delivered at the health centres. The infrastructure provision in the health sector is biased towards urban areas. In 1991, rural areas accounted for only 32% of hospitals and 20% of total hospital beds. The utilisation of primary health centres (PHC) is reflected in the percentage of illness episodes that are referred to them. In 1990 this varied from a low of 2% in M.P to 21% in Maharashtra (NCAER, 1992). The emphasis on higher level facilities, normally located in urban area has meant sharp rural urban disparities in the attainment of crucial human development indicators. Thus, the public health system was unable to provide the much-needed epidemiological surveillance services, which the NHP had strongly emphasised.

On the other hand, the private health sector has flourished largely because of state subsidies in the form of soft loans to set up medical practices, tax concession on the import of sophisticated equipment, the low cost of medical education etc. Therefore, the main stay of private health

sector – and even the public/government sector-is curative care which has rapidly grown over the years, largely due to lack of interest by the nation state in non-hospital medical care services mainly in rural areas (Jesani, et al 1993). **It has been established that the private health sector accounts for over 70% of all primary medical care, which is sought, and over 40% of all hospital care**. This is distressing and dismal for a country where over 1/3rd of the population live at or below subsistence level[9] (NSS 1987, Duggal and Amin 1987, Thankappan et al. 1987, NCAER 1992, George et al 1992 in VHAI 1997), unable to access care.

The model of health care development with poor participatory strategies perpetuated the maintained inequities and given the new economic policies of the 90s has further exacerbated the inequities. Therefore, a serious consideration has to be given to the current framework of the health delivery mechanism, policy perceptions on participation and the mechanisms for effective delivery, which will make primary health care in terms of day to day needs of the people a reality.

b. Financial Commitment

Another critical factor is financing. The effectiveness of expenditure incurred in terms of human development outcomes, and the relative importance of economic growth and public provisioning in capability enhancement of Indian states have been considered recently by Chelliah and Sudarshan (ed. 1999). Much needs to be done towards sprucing the overall government financing of rural development and social services - manpower, infrastructure, decentralisation of services, utilisation of funds and quality of care. Despite repeated reiteration of good intention to accord greater priority to that of human security as such, there has been an uneven performance, falling short of even the 50% required performance rate. During 1992-5, the average utilisation rate for all the states was a little over 44%. During the 8th Plan outlay 60% was the best performance and not a mean average. The reason for this gross under utilisation is believed to be inadequate capacity in state governments to implement programmes sponsored by the centre.

9 There are some glaring examples of disregard to public health policy directions by the government

For instance, the NHP is against 'vertical' programmes, and advocates that the existing vertical programmes like the National Malaria eradication programme, Family welfare etc. be emerged (horizontal) into the general health services. However, in practice not only has this been brushed aside, but new vertical programmes such as HIV/AIDS and separate organisations like the National AIDS control organisations (NACO) were founded outside the Ministry of Health. The revised Tuberculosis programme sets a bad example as well, in this case a programme, which was integral part of general health services, has been converted into the vertical programme.

India spends about 7% of its GDP on health (Prabhu in Chelliah and Sudarshan 1999). This is relatively high for developing countries. Rural households spend 4% of their income on an average on treatment of common ailments but the poor spend 9% of their income. Per person expenditure does not change according to household income or by land-holding category. The professionals and salaried spend larger amounts in comparison to wage earners. Additionally there is gender parity at lower levels of expenditure. However higher expenditure is normally associated with high gender disparity. Household expenditure on health care is higher for males in the early ages, which gradually falls and increases again as age increases. (NCAER, 1999). The expenditure on health accounts for 75% of total household expenditure. This high proportion of household expenditure indicates a relatively high disease burden and poor quality of services provided in public health-care centres. But, the aggregate expenditure statistics mask the fact that over 65% of beds are in government hospitals. The government is also the principal source of preventive and promotive health care. Poor health outcomes relative to the amounts spent on it show that both public and private health facilities are substandard. 2/3 of all deliveries are unattended and only one out of four deliveries take place in institutions. Available data also highlights the fact that private household expenditure is predominant in curative primary care, which accounts for about 46% of total health expenditure. Secondary and tertiary (hospital) care accounts for 27% of the total expenditure. Although direct treatment costs in public hospitals are largely subsidised, households have to bear substantial costs for the purchase of medicines (owing to shortages in public dispensaries), food and transport. Hence, the burden of both short duration and major morbidity falls on the vulnerable sections of the population, which includes low-income groups, minorities and wage labourers. The household expenditure on treatment of sickness is substantial and therefore cuts in public expenditure as a result of economic reforms and privatisation of health care will adversely affect the poor and vulnerable. Making the situation worse, there is no financial protection against illness for the majority of the population.

A detailed examination of the intra-sectoral allocation of the Union Government, (Prabhu 1997c) reveals a shift in the pattern of expenditure towards primary level facilities in education and health in the urban areas, whereas in the rural development sector the shift has been towards rural employment. Thus while trends in the levels and patterns of Union Government expenditures on rural development and social services have been encouraging, the impact of this favourable development is likely to be limited owing to a number of factors.

The social service expenditure indicate the level of spending, but the pattern of spending and its orientation towards basic level facility tells us more importantly the human priority expenditures across states. In the fifth plan period, as against a mean human priority expenditure level of Rs.38, Kerala recorded as the highest level of Rs.62 among 14 states of which data is available[10] the lowest level was recorded in UP where it was Rs.29 per capita. In the post adjustment period Gujarat recorded the highest level of human priority expenditure Rs.107 as against an average of 14 states of Rs.80. Tamil Nadu obtained 2nd rank with a per capita spending of 103, even as Kerala's spending of Rs.68 is much lower than that recorded in other states (See Annexure – 1).

Another point that needs serious consideration is the state wise trends in growth rate of revenue expenditure on social services. The decline in the relative share of social services in the total revenue expenditure raises questions regarding trends in growth rates of social sector expenditure. Prabhu and Sarker 1997 indicates a deceleration in the growth rates of social service expenditures in most rates since the mid-1980's. This deceleration in the growth rates in social services expenditures in major states since the 1980's might have had grave implications for human poverty and is a matter that requires immediate policy attention (Refer Annexure – II).

Further, social sector allocations are almost all absorbed by staffing costs. Little remains for capital investments and the maintenance of essential infrastructure. The bulk of public expenditure for health is appropriated for recurrent costs, with 62% spent on salaries. Maintenance costs account for about 20%, capital investment in building and machinery for about 7% and transfer to local bodies for 11% (average of 14 major states in 1985-90, NIPFP, 1993, World Bank 1995: 22)

Having acknowledged the poor state of infrastructure and diminishing health expenditure in the past two decades, it becomes necessary to investigate the nature of linkages between infrastructure, per capita expenditure, and attainment in the health sectors. Infrastructure represents the fructification of capital expenditure incurred in the past, whereas per capita revenue expenditure goes towards the maintenance of various health facilities. The ranking of Indian states according to health infrastructure, attainment, and per capita government expenditure for two time points 1983-86

10 Human priority expenditures have been defined to include expenditure on elementary education, primary health (comprising public health, rural health services and family welfare), water supply and sanitation and nutrition.

and 1988-91 was considered[11]. It was found that, in the health sector the coefficient of infrastructure development was statistically significant, while the coefficient of per capita expenditure was statistically insignificant. This implies the relative importance of the infrastructure in the health structure and the necessary capital expenditure for attainment of health objectives.

There also exists a wide variation in the levels of per capita social expenditure among states. Between 1985-92, there has been a sharp deceleration in the rate of growth of state per capita social expenditure. In comparison to the high-income states, the Per capita expenditure on maternal and public health in low-income states is about one third to that of high-income states. Differences in levels of spending were more pronounced with respect to the expenditure on disease-control programmes, which are partly financed by central government[12]. These patterns indicate that the relationship between needs and resources are lopsided and unbalanced. (Prabhu in Chelliah and Sudarshan, 1999).

The expenditure incurred on rural development and social sectors can get translated into better human development outcomes only if the allocated funds are effectively spent. It has been repeatedly pointed out that the impact of the levels of expenditure incurred, as well as the trends in such expenditures, depend to a

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11 Prabhu and Chatterjee 1993 have constructed indices using the principle component method Rank correlation coefficient has been completed for the health sector for two time periods 198306 and 988-91.

In the case of health sector infrastructure ranks are highly correlated with attainment ranks even as the correlation between per capita expenditure ranks and attainment ranks is relative lower, at 0.54 and 0.53 in the first and second time period respectively. It is interesting to note that the rank correlation of health infrastructure with health attainment is remarkably consistent at 0.82 in both time points. The results of regression analysis are similar. In the health sector the coefficient of infrastructure development is statistically significant, while the coefficient of per capita expenditures is statistically insignificant. Therefore the relative importance of the infrastructure of the infrastructure in the health structure implies capital expenditure for health attainment and is stressed by the World Bank as well. .

The regression analysis shows that economic growth as well as public provision constitutes two equally important routes in influencing poverty levels. The results seem to suggest State Domestic Product growth is meaningful only if it is accompanied by rural development and social sector expenditure. The above analysis highlights that deceleration in the social sector expenditures particularly since the mid 1980s poses questions regarding the priority given to human development in the Indian states. The relative importance of per capita revenue expenditure for infrastructure for health attainment highlights the areas on which greater attention needs to be paid for improving human development outcomes. Reference: "Income Poverty and Beyond-Human Development in India", Chelliah.J. Raja, Sudarshan .R, Social Science Press, New Delhi, 1999.

Reference: Report of the independent Commission on Health in India, Voluntary Health Association of India, 1997.

12 Real per capita health-related expenditure, was highest in Rajasthan (mainly on water supply and sanitation), Punjab and Tamil Nadu. It was lowest in Bihar, Uttar Pradesh and Andhra Pradesh. IN 1990-91, public health as a proportion of total state expenditure varied from 5 per cent in Rajasthan to 28 percent in Maharashtra. (Prabhu 1997b, pp.143).

large extent on the efficacy with which they are translated into outcomes that reduce human poverty. It is useful to analyse available evidence on the efficacy on the government expenditures incurred on select items like social assistance schemes, nutrition programmes, and health among others.

Therefore, as of today, there are severe imbalances in India between public and private health care; and within public health care between preventive and curative services; between primary, secondary and tertiary health care services; and between salary expenses and other recurrent expenditures. Besides, anti-poverty programmes have failed to take into account the strong nexus between health and poverty and for those trapped in poverty the crises in the health sector spells calamity (UNDP 1997 b). As this paper goes to print the allocation for the Reproductive and Child Health Programme has been announced in Budget 2000-01. It will receive Rs.1,051 crores as against an allocation of Rs.695 crores in 1999-2000.

c. *Regional Diversities and Contrasts in Health Status*

Given the extremely heterogeneous character of the Indian economy and society, India's achievements and failures cannot be understood in composite term. It is essential to examine the experiences in sufficiently disaggregative forms – and in adequate detail. Until now, the experts had judged the health status of the people, by three primary indicators, (a) general mortality, (b) infant mortality and (c) expectation of life at birth. However, now studies on fertility, morbidity, the impact of health programs and the use of health services have been incorporated to assess the health status of people[13]. A few NGOs in India have specifically been involved in budget analysis and lobbying with the government on effective social sector expenditure. The issue of securities requires some attention in the larger

13 Banerjee (1998, pp.15), elaborates on the definition of health status of group of people, by stating that it is also determined by a very complex interaction of (a) the human host, (b) the environment-in the widest of the term and (c) the causative agents.

The human host responds in multiple ways in coping with a large variety of threats to its health: developments in the immune system, both in the positive and negative sense, constitute the highly complex host system. In the vast environment system-water, sanitation, housing, ecological considerations concerning a large variety of animate and inanimate elements is included. Causative agents affecting the health status bring to the attention innumerable biological, physical, and chemical disease-producing agents.

Making the situation further complex is that these factors are always in a state of flux. They undergo so many changes over time that it becomes impossible to keep a track of these changes by even the most advanced nations. For instance, one of the examples is the near impossibility of making forecasts of short-range trends in the incidence of HIV/AIDS as a public health problem in our nations.

framework of social assistance schemes[14]. It is very clear that matters of for example food security such as in Kerala where the Public Distribution System has worked very successfully are also principal components in ensuring an overall equitable health profile. The India case has been characterised by two broad approaches in the area of food security and nutrition: represented by the PDS with its wide and untargeted coverage and specific targeted programmes such as ICDS and state sponsored programmes for the benefit of the vulnerable sections of the population. The nutrition programme introduced in 1992 is the largest such programme providing midday meals to the children in the age group of 2-15 years in their schools and nurseries. Old age pensioners have also been considered eligible for midday meals since 1983.

An evaluation of the impact of the midday meal scheme in Coimbatore district by Harris, (1991) reports that the programme has not led to an increase in the height of children but there have been substantial gains for female children. TNs integrated nutrition project operating in all districts is a more comprehensive programme covering nutrition needs for children in the 6-36 months age groups as well as pregnant women and nursing mothers. Among these schemes, Subba Rao (1992) considers integrated nutrition project to be better targeted. The target efficiency in these programmes is high on account of the fact that benefits are small enough for the non-poor to desist from infiltrating. No ceiling are placed on the number of beneficiaries assisted and there is no problem of moral hazard. As against the nutrition programme of TN the problems associated with the PDS such as lack of targeting, leakages and irregular and inadequate supplies have rendered it an ineffective instrument for ensuring protection of the nutrition entitlements of the vulnerable population.

Looking at the states of Kerala and Uttar Pradesh, Kerala's achievements in the social fields have been quite remarkable, including an achieved life expectancy of well over 72 years (69 for males and 74 for females by 1991) which compares well with China's (69 years) and South Korea's (71 years) achievements, despite the much greater economic advancement of these other countries. At the other end of the

14 TN and Kerala are two states, which have implemented a variety of schemes for the benefit of the destitute and the weaker section of population. The social security schemes in TN include old age pension, destitute widow pension, destitute and deserted women's pension, destitute agricultural labourers pension, and marriage assistance for orphan girls for daughters of poor widows. Guhan 1993, has estimated that 732,000 poor households out of an estimated 4.4 million, about 17% have been protected from contingencies which could have made them poorer. Out of the total beneficiaries at least 57% were women mainly deserted women, widows, working mothers, brides belonging to poorer households. The major of this scheme was the inadequacy of amounts disbursed Rs.75 to Rs.100 to enable the individual to cross the poverty line narrowly and rigidly defined eligibility criteria leading to high rate of rejection of eligible applicants, and high opportunity costs of obtaining information and applying for assistance.

spectrum, Uttar Pradesh remains one of the most backward states in India, with 140 million people. Had this state been an independent country, it would have been not only one of the largest, but also one of the most socially deprived countries in this world - giving its citizens less than some of the worst-performing economies in Sub-Saharan Africa. Hence, the broad aggregate masks vast disparities within India.

Progress over the decades has been uneven and has remained confined to more advanced states and even within them, to selected regions only. The health status of a large part of the Hindi speaking areas of north India, as well as the states of Orissa and Assam, remain adamantly vulnerable. Even in the more advanced states, like Kerala, there are pockets of depressed and lagging areas, for example, the Malabar Coast and the Kerala highlands. The short duration Morbidity Prevalence Rate (MPR-SD) for all India was estimated to be 122 per 1000 population for a 30 days reference period. Women recorded marginally higher MPRs (127) than men (117) and the gender disparity worked out to be 1.08. The short duration morbidity was high in Madhya Pradesh, West Bengal, Tamil Nadu, Punjab, Haryana, Orissa, and Andhra Pradesh, and low in Gujarat, Maharashtra, Kerala, UP and Rajasthan. Very high female morbidity in comparison with male morbidity was reported from Tamil Nadu followed by Punjab, Haryana and Orissa. (See Annexure III for more information).

About 41 million people suffer from major morbidity at a given point of time in rural India. The southern states of Kerala, Tamil Nadu and Andhra Pradesh show a higher proportion of morbidity (NCAER,1999). It is also true that the more remote sparsely populated and resource poor an area is, the greater are the chances of its neglect, in terms of the availability and effectiveness of health services. The stretch of tribal areas extending from West Bengal to Maharashtra and Gujarat, record high levels of morbidity, arising from malnutrition, forced displacement of people and changes in traditional lifestyles because of unregulated mining and urban development. The scheduled tribes have the highest prevalence of diarrhoea and fever. The desert and arid zones of the western frontier, sub-Himalayan hilly and terai tracts of Bihar, Himachal Pradesh, Jammu and Kashmir, Uttar Pradesh suffer from continuous failure of rains and consequent migration of people. The flood prone areas of Assam and Bihar and states lying along the Bay of Bengal suffer from the endemic presence of vector-borne diseases and frequent damage to infrastructure.

The people in the above mentioned areas – be they tribals, scheduled castes, displaced or migrant populations in search of work remain ignored and are compelled to accept a lower quality of life. Preventive

and Public health care measures and primary health care services do not reach them adequately. Therefore, the political economy impinging on health policy development and its implementation has given rise to the conspicuous disparity in the health outcome. As a result, there has been – neglected areas, forgotten populations and overlooked issues. Each of these distortions is damaging enough, but when all three exist, then the situation is acute and of persistent vulnerability – a phenomenon that call for immediate attention.

A few year ago, the Independent Commission of Health in India (VHAI, 1997) conducted an extensive exercises and identified some of the regions and states which could be termed the most vulnerable with regard to health and development. The health status was defined by health and demographic factors like the crude death rate, infant mortality rate and fertility rate, environmental factors - which were considered to influencing morbidity and mortality, and nutrition and income level of the people.

Making use of the 1991 Census of India household level information (rural as well as urban) on housing and basic amenities like availability of safe drinking water, toilet facilities and electricity, type of fuel used for cooking, etc. the Commission constructed a Household Misery Index (HMI), which reflected the extent of deprivation at the household level of basic needs líke pucca housing, safe drinking water, toilet facilities and electricity and also availability of proper fuel for cooking. To validate the results, a comparison was also done with the estimates of fertility, mortality and infant mortality for 1981 for each district, as presented by the Office of the Registrar General of India (GOI, 1994b).

The findings of the analysis clearly highlighted that the states of Orissa, Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh and the entire North - East region were vulnerable in terms of health and development. Interestingly, the analysis also brought out that the most vulnerable are also invariably found in the following areas. (a) Hilly/mountains (b) Tribal (c) Arid/semi-arid (including desert) (d) Drought-prone (e) Flood-Prone (f) Water – logged (g) marshy (h) Coastal. Notably, it was observed that even comparatively developed states had vulnerable districts, while most underdeveloped states had a few districts, which were moderately vulnerable. For instance, in Kerala[15], the Census figure for households with safe drinking water is only 18.9 % compared to 46.3% in Andhra Pradesh and 67.0 % in Tamil Nadu. Based on the findings, the Commission called for a thorough

15 It could be the census instructions may not have been properly followed in Kerala.

restructuring of the health delivery system and above all, a rethinking on the critical and neglected health sector within the development context.

This comparisons of enormous variations in achieving social progress of different states in India provides insights of the direct role of the state in raising well-being and in reducing human deprivation. Besides, it also highlight the indirect part they can play in enhancing the nature and quality of economic growth as well as understanding of a crucial aspects of the needed radicalism.

Additionally, the analysis would supplement the learning from abroad, which has been a crucial factor in the recent economic debates in India. The lessons learnt from the states within India need to be integrated firmly into the understanding we have from experiences abroad. Hence, the questions that need to be asked is why – and to what extent – Kerala has succeeded, and why Uttar Pradesh has failed so badly in precisely those fields? Of course the answers to these questions need to be sought locally and implemented[16]. It becomes imperative to identify the successes and deficiencies and link them with the nature of policies pursued and the over all political economy of the states.

III. *Reform of the State and the Role of Civil Society: A Case for Co-operative Public Action*

"My concern at the present historical juncture is to understand the possibilities for real, incremental changes in the lives of those rendered invisible by the powerful configurations of lending institutions, governments, and other power blocs which accelerate or decelerate oppression at will. It is crucial that the struggle being waged by highly dedicated efforts all over the country not be fragmented and internally eroded by the remote processes being unleashed on the polity and the inchoate darkness that resistance finds itself in. I suggest that, if we are to resist the dystopia of the real world, the definitions of civil society need to be broadened: They must include the dispossessed, often left out of the processes of political and social decision-making, except when regarded as vote-banks. Political decentralisation is the only response to globalisation, which today widens its scope despite an increasingly narrow social base. Social movements in

16 The major issues that have been overlooked in the past and have an impact on the health status are: Occupational-related health problems of workers employed in stone quarrying, leather industry etc., children employed in the bangles, fire works and match, carpet etc., have not received appropriate and sustained attention. There is also the absence of a defined role or regulation in the functioning of the private sector in medicine, even though a large portion of the health expenditure, especially among the poor, is spent on private medical care. Another overlooked concern is the need to pattern a system of health care that responds to seasonable variations in the availability of work, income, food to rural labour, and the ways in which they influence preventive and curative care.

their political practice are also 'globalising', building up linkages, and altering the character of public-interest institutions, so that the latter not only represent mass movements but also unite organically with the culture of that resistance" (Raghuram, 1998).

a. Civil Society Formations in India

With the role of the state changing so rapidly particularly in countries like India which were, until recently, wedded to socialist goals and strategies, but are now promoting privatization and deregulation, the role of voluntary organizations in civil society has been brought into sharp focus, calling for a reevaluation of their relations with government.

Traditionally many voluntary organizations have perceived themselves as public-interest institutions providing critiques of dominant systems, as 'conscience-keepers' of a nation, and as organizations 'closer to the field'. Social issues concerning questions of equity and justice have been critical to many South voluntary organizations. (North resistance groups have, of course, moved on different trajectories, what with a welfare state firmly in place, at least until recently.) However, the voluntary sector in India with a much older history is particularly heterogeneous in its affiliations, objectives, methods of action and internal structures. Many organizations are associated with entrepreneurial groups minimising the adverse impacts of certain types of economic growth. Some of the associations intervene directly on behalf of target groups (communities of tribals, fisherfolk, etc.), whereas others prefer to be catalysts, intermediary organizations linking with others and hoping, in the long run, to create self-reliance at the grassroots level. Several of the more professional bodies are large institutions, complex and hierarchical, with salaried staff, whereas others run as informal groups. Yet, others, in an effort to emphasise their grassroots nature, both in substance and form, claim to be 'promoting people-centered development at the micro level'. Issues taken up by grassroots voluntary organizations include food security, political participation, health, urban poverty, migration, and land alienation. (I will use the term NGOs to mean non-governmental organizations that are formal, non-profit organizations, which devote themselves to meeting socially identified needs).

The struggle for access and control over natural resources has been powerfully dominant in the history of the modern nation-states and the social systems they control and regulate. An equally important struggle is the one for knowledge and the control of information networks. These struggles accentuate the growing dimensions of power contestations and bring home the truth that the nation-state is no longer a unified entity, but a reflector of the various forces in society like class, caste and gender. In India, the nation

state as a powerful arbiter in cultural, social and economic wealth distribution has of late been inviting voluntary organizations to participate in government programmes. On the surface of things it would appear, then, that voluntary organizations are finally making their presence felt and that the acceleration in co-operation is a vindication that governments recognise and need them. However, the long-term view calls for caution and further introspection on the terms and conditionalities of this partnership, on the original charters of these institutions, and the contents of the proposed collaborative programmes. Many voluntary organizations have struggled with issues of power configurations, of race, class and gender in their communities; and they have waged a long struggle against the displacement of people and environmental devastation caused by the government via mega projects. Thus, voluntary organizations may now find it difficult to negotiate with or be partners of government. Those who have steadfastly opposed the World Bank and IMF policies in countries such as India may be unwilling to respond to the Bank's call for 'people's participation'. Indeed, a significant concern for people's groups in India is the dilution of ideology, perspectives and purposes. They believe that, in the long run, collaboration with governments and lending institutions cannot possibly accommodate, in real terms, a truly critical role. When a state is benevolent, these coalitions signal gentle co-optation at worst and progressive changes for the better for large sections of populations at best.

In India, the changes in voluntary organizations have been significant, particularly during the last fifty years. The genuine voluntary grassroots movements that joined Mahatma Gandhi led to an unparalleled mass movement of civil disobedience: 'Harijans', tribals, women in distress, corporate giants, and members of the nobility, all came forward to win freedom from British rule. With time, many were absorbed in the bureaucracy; and others, within the Congress Party, shed the virtues of voluntarism and fully integrated with the state's interests and those of the elite corporations. In the 'nation-building phase' the government set up several welfare boards and village industries, which, in some sense, signalled the beginnings of the bureaucratisation of voluntary sector. During several famines and with mounting destitution some voluntary organizations became active in service-delivery work, particularly in relief operations, providing food and health care. This was certainly a welcome collaboration, since the large-scale nature of the calamities required tremendous human resources to combat them.

"From the mid ' 70s to the '80s there was a significant growth of the professionalised voluntary sector in countries like India, because of the need felt by some public-interest institutions to engage actively in livelihood

issues such as forestry, health, and the protection of the commons in collaboration with government welfare wings. Left parties and trade unions perceived this collaborative effort as co-optation, no better than 'contractorship', but many of these efforts were not without their commitment." See Kaderplan Asia, Hivos, 1997.

The issues of ideological dilution and a partnership based on an unquestioning acceptance of the power coalitions of government have not been easy to resolve. Must all partnerships with government be perceived as a lowering of standards of political resistance and a sharpening of the service-delivery-resource capabilities (for example as in the area of health) of the voluntary organization?

"Governments have many mechanisms at their disposal for replicating good models that might emerge from the extensive micro-level experience that non-governmental organizations have of given communities, which helps them to perceive genuine interests and to build organic links on the field. The state conceives of development in national terms. Non-party political processes can be critically engaged by dealing with local interests. However, despite the competi-tive advantages at the micro level and first-hand information that they often have, the question remains whether they can really short-circuit the structures of domination created by local elites, which use the state apparatus to maintain themselves: Much depends on the internal political and social strength of the public-interest institution if it is to be an effective partner of government, consistently representing the poor and yet willing to share responsibilities in civil society." See Kaderplan, 1997.

In the area of health, which involves a spectrum of collaborative efforts, politically voluntary organizations need their autonomy from government; as they instrumentalise different social and political interests. As suggested earlier, in the present phase of liberalisation, where major portions of the economy are being handed over to corporate capitalism, the co-operation between government and public interest institutions is perforce based on an uneasy relationship. The voluntary sector is itself being polarised on such issues and the social consequences of alliances. The mutual accountability, that is being demanded of government-voluntary organization relations, requires institutional integrity (e.g., transparency), particularly to the communities involved. How they may be asked to integrate their efforts with those of the state, which is itself in the process of integration with global interests on terms clearly not set by the people themselves, is a thorny and painful issue.

Democratic and decentralised planning in the area of health securities (budget allocations and sectoral heads), policy formulations, implementation (choice of agencies) will include extensive co-operation of people's organizations if they are to have a meaningful role in making history. In this context it is useful to widen the interpretation of popular participation to include its contribution to the satisfaction of both important material and non-material needs of human beings such

as food and health security as important denominators of equity, social justice, human rights and related freedoms. If institutions in civil society, particularly voluntary associations and social movements, are to draw up the terms of co-operation with government, those agendas can be neither unilateral in content nor linear in decision making. The economic social-justice agendas may, in many cases, be closely linked to cultural and political-rights agendas. Political decision making cannot rest with government alone and partnership with government can only be founded on the firm ground of equality. Unfortunately, the term 'participatory' hardly reflects democratic decision-making and the sharing of power in the best traditions. The term is, more often than not, used by institutions in power to pretend that people's views have been sought, realized and their consent now secured. Many registered voluntary bodies are themselves often-intermediary organizations, 'claiming' to represent several communities of people; by the time governments, multilateral lending institutions and donors seek to have these communities represented, the 'true' representatives may or may not have lasted out the highly complex process of 'selection and rejection'.

The number of public collectives are increasing- they are diverse in nature and differ in organisational structures. The Home Ministry in India has declared that there are about 48,000 NGOs registered under the Foreign Contribution Regulation Act, which qualifies them to receive foreign funding. The total number of voluntary organizations engaged in the country in basic needs issues and particularly in health-sadly, no data is available on this. The inventories that exist today are much more limited in scope. They range from actual service delivery in health care to training centres for health provisions. Despite the lack of data, it is clear that the presence of organised dissent in civil society may not be taken lightly by policy makers. At almost every meeting between government and NGOs in the area of health and other allied securities, there have been contentious debates because of the existing mistrust on both sides. Therefore, the real problem is in the terms of co-operation, especially when corrupt governments are relentlessly capturing resources, organizations, community platforms and bureaucracies. Their infinite capacity to enlarge the soft state cannot be underestimated (it is often said that the soft state has no borders and that rent-seeking is hard to tame); so voluntary organizations may find, as in India, that co-operation, equal decision making and equal participation with corrupt governments can leave only two options: rejection or co-optation. As long as it is impossible to maintain high standards of fiscal, political and social accountability, and transparency, it may well turn out that they can only exercise the politics of resistance and not that of co-operation with government. This may hold true now, more than ever before, considering the rapid loss of national sovereignty as governments of South

countries invite indebtedness and loss of self-reliance by accepting countless development grants and loans which create more vertical structures, making more difficult people's access to direct heath care.

The voluntary sector is itself not without its difficulties. What about the indebtedness (in fiscal, social and political terms) of non-governmental organizations in the long run? Their financial dependency on external funding institutions puts immense and untold pressure on honest and politically committed voluntary organizations on the one hand; and it exacerbates, on the other hand, the tendencies in some organizations to consider this issue itself irrelevant. The markets put a premium on generating resources of their own; and nation states in their normal course of authority do make financial allocations; but they are by and large motivated by reasons of 'interests'. Moral authority and political commitment often prove insufficient for obtaining financial support. "Who pays for development?" is a question that is easy to ask but difficult to think through. The tremendous heterogeneity of civil society, in which public-interest institutions, private and state sectors are not-so-equal competitors for resources, implies that the road to self-sufficiency for development organizations may be a long and never-ending one. Voluntary organizations have made valid critiques of governments and state 'irresponsibility'; however, self-criticism may also be necessary to put the discussion of self-reliance on a sound footing.

These emerge from a painstaking process that calls for a marriage between considered theoretical positions and the internal political commitment to withdraw, when necessary, and to replicate appropriate social and political action. While radical organizations may often be divided over strategies, diverse analyses, and their own raison d'être, they need to be united on at least a few non-negotiables. We suggest that these include sustainability and self-reliance. Both these critical variables can really alter the spirit and politics of a movement. The numerous internal fragmentations caused by state action within civil society call for unification rather than disunities. If they are to play a catalytic role, voluntary organizations must be sufficiently disengaged from the content and form of the institutions they are critical of and that of their donors. If political and social freedom is to be a supreme value, surely self-reliance in social, political and economic terms cannot be over emphasised. The undermining of people's access to medication by the drug-pricing adjustments is only one case in illustration. Health for all cannot be achieved when the 'all' is not committed to similar issues of providing supportive care to those in ill-health regardless of income capabilities.

b. The Practice of Resistance

Major debates have occurred in the country decrying the continued tolerance of public 'bads' but the defense of the public good calls for wide-reaching social

reforms, responsibility for which needs to be undertaken in unison by various movements, corporate and public-interest bodies, government and individuals on the basis of a minimum agenda: This minimum agenda must fortify the human agencies of empowerment and negate 'minimalist' positions regarding human happiness. Health must be regarded in this manner. The theology of the market, which tries to treat 'responsibility' in cost-ratio terms, must be countered with the view from below, defining 'responsibility' as 'trusteeship'. Social justice, accountability, high standards of morality and equality are issues that cannot be realized historically without majority consensus. For voluntary organizations or social movements the challenge lies in enabling basic needs and democracy mainstream concerns, cutting across social strata and class interests. Community health care centres often reflect the unique ethics of care, a principle that can defy the logic of privatisation and uphold the causes of community ownership.

Through the structural adjustment policies, the state is slowly being replaced by the power of the markets; and many activists and thinkers have been concerned that the call to 'strengthen civil society' has been made only in view of the state withdrawing from its responsibilities. The contraction of the state has been, and continues to be, resisted by citizens' organizations in most developing countries. The state in reducing its obligations of regulation and protection of the social interests of the poor, during the reform process promotes a free passage for markets, leaving the poor and issues of their survival further marginalised. Nor should the neo-liberal idealised vision of markets in the era of globalisation be accepted as the cure for the excesses of the nation state, such as corruption, poor governance, and ineffective social-justice-delivery systems. In the area of human securities especially education and health if a state must be contractionist, it must be so in the matter of its omissions; and it must be expansionist in promoting accountability, the sovereignty of the poor and their communities, and decentralised administration. The role of the local bodies offer today the only hope in benevolent, decentralised state presence, where the centre may hold and the peripheries may continue to define political visions. A visit across the length and the breadth of the country to hospitals run in the most remote corners of India by both religious and non-religious organisations committed to tending to the poor will give us an idea of what it takes to make institutions really work for the people. Real democracy fosters local action and, therefore, stakes globally the claims of its members. We submit that the area of health has to be contextualised in the larger politics of social change which calls for a restructuring of the systems of power and at the same time constructing the viable alternative which provides the care that is needed at the local level.

c. *Co-operation in Health Strategies*

Field realities are showing up severe destitution for disadvantaged sectors. The poverty trap results in multiple deprivations and NGOs involved in health services are having to contend with a state structure of health care that has not shown a political will towards this class of problems: lack of easy access for the needy, poor quality of services; expenditure of health accounting for 75% of total household expenditure; deceleration of government spending on social sector expenditure, etc. When the government is the principal source of preventive and promotive health care there has to be clarity as to what are the complementary roles to be played by the independent sector. There is hardly any financial protection against illness and it is clear that there needs to be dovetailing of all financial schemes to get a clear idea of the overall financial outlays and the gaps both location and disease specific. The sharp rural-urban disparities in the attainment of human possibilities with almost 52% unable to access avenues for capabilities, makes the problem of health burdens private hells for the victims particularly in the absence of public succour and empowered literacy for the majority. The sharp gender, poverty, caste lines and the scarcity of resources makes the need for extensive field co-operation an urgent matter. Particularly in preventive work, information dissemination and communication, and in pressurising the inflexible medical bureaucracies to extend support in implementation, NGOs today are accelerating their work. The dogmas that dog the subject are also being addressed by those citizens involved in education, training and counselling. The work of NGOs is preventive, proactive, promotive and emancipatory. Traditionally NGOs strength is in training, in public interest activism, and not in service delivery alone. NGOs have shown the strength of being embedded in community survival issues. Their ideas on information, education and communication (IEC) cover a large number of problems faced by the poor and by women in particular; therefore a large number of them anchor these issues in an economic, political, social and civil rights agenda.

The next millennium must reduce the inequities in health care system by developing a quality of partnership, which is always critical for the success of programmes. The nature of commitment has to be long-term with committed faith in the social objectives, a willingness to follow ethical guidelines, and, governments cannot treat NGOs as token representation and vice versa. Of course, to not treat communities as 'targetted' users but to have them involved in planning, decision-making and in ensuring the efficacy and effectiveness of programmes is well worth remembering. The acceptability of the approach to both the member of the community and to health providers ensures sustainability, a

key denominator. All social actors need to be critically reflexive. The establishment of baselines and monitoring at the beginning of a health programme has proved greatly helpful in assessing the situation.

When we use technology to aid us we should be aware that there are no technical fixes to social problems- reproductive health rights, autonomy in decision-making, equality between men and women, the rights of citizenship, accountability in handling public funds etc., are the foundations on which health services must be built. Critical areas of partnership are counselling, understanding local cultures and building absorption and acceptability strategies, speaking the language of the 'other', and the constituencies. Partnership building at microlevels are long-term and slow. The training services and training of trainers will help in multiplying scarce resources. Information must be in multiple forms of dispersion, including well-considered campaigns. IEC if successful will ensure informed decision-making, quality safe care services and the pursuit of universal goals. Information is not static. Data has to communicated as a living piece of reality with existential implications. Data on IMR, MMR shortcomings need to be translated into implementation policy. This will strengthen and decentralise available health care. In education there is enough experience and NGOs have shown that it is not simply in the mode of expert-non expert.

The most successful empowerment programmes have been based on education by learning, recognising the rights available to us and realising more rights- The expansion of choices and the right to decide in an education that want to empowers its subjects. Communication is quite central to the effective success of programmes in public health. Health workers are the central agencies of the policy framework being materialised on the field and often this is a neglected fact. Barefoot health workers, centrally involved in communication are often shoddily treated in their working conditions, creating a tremendous demoralisation in programmes. People accept and follow when they believe and have faith in the fieldwork. Many voluntary organisations today have evolved because of committed interventions–not conflicting but co-operative, not rigid but flexible, dynamic, and non-cumbersome. Financing too has to be creative, and public interest work in the basic needs approaches has to be historically dynamic.

We speak of changing the mind-set of the disadvantaged but it is important for also well-established private bodies to change their minds and also their hearts. We live in times where poverty is tolerated and where women's lives especially when they are poor are a devalued social goal, when

basic health issues are not perceived in the larger context of poverty, human development and the realisation of rights. The challenge for programmes like IEC is for socially marketing health goals or social communication, which will seriously challenge these values, which deny livelihood with dignity. There are no quick fixes in human development and tremendous inhuman suffering of the poor due to ill health calls for urgent solutions. The corporate sector needs to be sensitised on social responsibility and so must governments who treat human welfare concerns as soft options. So must NGOs also be involved in communication of data and conveying implications of this data and this practice! This class of problems deserves extraordinary attention for policy makers and donors and the will to put on a war footing the minimalisation of maternal mortality, various disease burdens, poor health conditions triggered by immiserisation, etc and the maximisation of social opportunities, good health being a major public good.

Some key policy questions are: What are appropriate and effective roles for public action, especially by government? How do we improve access, effectiveness and impact of India's health care services? Customarily, government policy has focussed on planning and implementing direct public services. The excessive concentration on the provisions of imperfect public services has resulted in the comparative neglect of policy instruments beyond direct services. Legislation and regulation have not kept pace with the necessity of ensuring the quality and safety of commercial systems, including the pharmaceutical industry. The policy instruments of taxation, subsidies and fiscal support of public health have not kept pace with the growing need for sustainability. Compartmentalisation of government departments has dampened a broad, inclusive developmental approach to health in India. Clean water and sanitation, universal primary education, especially of girls, more effective distribution of food and nutrition, the alleviation of poverty and greater public awareness and participation in health preservation and care are all critical components of genuine health and development strategies. Many challenges face Indian health policy makers. Can universal care be afforded and managed by the public sector alone? How can appropriate fiscal, human resources, and social systems be developed to achieve this goal? Could decentralisation of health policy help in this process? How best can the public and private sectors be made to interact to achieve better health outcomes? How can information dissemination be accelerated to enable people to make the crucial transition to protecting their own health more effectively? These are some of the major challenges confronting the future of health in India. An important question in the relationship between health and development is the question of what priority our country gives to health among its various development goals. The share of total national income devoted to health

indicates a measure of the value accorded to health. However, it is important also to examine how effectively these funds are being used in improving health levels in the country as a whole. The question of health financing in India has only recently begun to be addressed in a serious fashion. We are far from having even the necessary information on which to base new policy directions, let alone to tackle the complex political implications of evolving a model of health care financing which is sustainable quality conscious.

d. Growth, Equity and Self-interest

Self interest has been often an obstacle to institutions delivering quality and responsible services[11]. Basu points out that sometimes large social expenditures may not necessarily lead to a better quality of life. One region with a small expenditure can achieve what another with a large expenditure fails to because of differences in methods of allocation and efficiency. For instance, both in Kerala and West Bengal, the volume of medical facilities available is comparable but utilisation is much higher in Kerala (Nag 1983 in Kaushik 1991). As a consequence, Kerala's performance is much better than that of West Bengal's in the health statistics. Therefore, while a certain volume of social expenditure is necessary to improve living standards it may not be a sufficient condition. In this context, Sri Lanka which has had a long history of free education – dating back from its pre - independence period - has contributed for the success of the health programme. The same is true for Kerala, where the state's progressive health policies go far back into history, to the policies of the princely state of Travancore. (Panikar and Soman, 1984 in Basu, 1991).

Another concern that is often discussed and debated is the larger macro-economic one of the alleged trade-off between growth and equity. Basu (1991) asserts that the reason of the widespread belief of trade off is that policies come as a package. The government that encourages control – actions that are often perceived to have negative impact on growth-is also the one that promotes more radical poverty elevation programmes bringing about greater equity. This is an exaggerated view of trade off and in particular a false view that increased social spending must result in sluggish growth. It could well be that a country that takes up an activity with zeal could also perform other activities with equal zeal. Therefore, Basu 1991, affirms that it is not necessary to prune social sector spending in order to have growth. Growth can be supported through different set of policy instruments while continuing with the same basic needs priorities. However, it might be necessary to restrict the recipients of government support and subsidies to the really needy. Selectivity needs to be exercised as the access of the middle classes to the subsidised securities have diluted the legitimacy and the sustainability score of public health care services.

Nevertheless, what can be implemented or sustained depends on the political climate of countries. Keith Griffin (1985) in Basu 1991 states "the problem of poverty and well-being can be largely eliminated through a purposeful government intervention; but 'given the class basis of the state, a question arises about the possibility of effective action'. In most South Asian countries, governments are closely in alliance with the wealthier sections of society, who are guiding policy to their advantage. The governments rhetoric is meant for the poor who are near enough to feel the impact of actual policies, and "the actual policies are inclined to help the already wealthy who keep a close watch on them". Myrdal (1970) also supports this view by stating that not only policies but also even the perception of truth can deviate in favour of the dominant class. However, Basu (1991) counters this argument by stating that if this all-encompassing explanation was justified then there would be no point in making policy recommendations. First, people do not always act selfishly and aspire for more equitable policies lies in the fact that altruism, the influence of writings, envy, anger can urge us to act against our own interest. Second, although the rich constitute an influential group and even though a particular policy may be in their own interest they may fail to implement it because their individual rationality might be incongruous with the groups rational behaviour. Third, even though governments may exhibit class bias there would be cracks in the system, which can be exploited to divert the resources for the poor. Therefore, if government polices are to be influenced efforts should be made to alter the constraints. The poorer sections have to be made more demanding and conscious of their rights. This of course places a tremendous burden on the poor- that they have to be also on the forefront of resistance. It is clear that the role of intermediate NGOs is to precisely be in this position where they play a supportive role to the rights due to all citizens, rich or poor.

Finally, the values of one particular programme for instance, public health e.g., will depend on what kinds of policies are being implemented in other sectors. Some complementarities, for e.g., food rationing, access to safe drinking water, higher literacy rates among women need to be accessed for a systematic evaluation of policy package. The overall binding philosophy has to be directed at ensuring equity in favour of the poor. This necessitates devolving powers and the devolution of funds to the base structures. The programme's efficiency rests on stressing preventive measures over curative strategies. International and national commitments need to be confirmed, procured and consolidated, if not in the actual disbursements at least in the programmatic content. And, most important of all the overriding success may only be secured in the commonly shared will in wanting to ensure that health is everyone's right. This calls for a complete rethinking on the part of government to

alter its culture of working and its frame of priorities.

Conclusion

"Health policies are disease policies. A central health policy should combine information, education, and social communication with the individual and family as the fundamental resource."

(David Tejada, Peru Latin America Public Hearing, Independent Commission on Population and Quality of Life, OUP, NY, 1996. p. 211.)

The time has come for governments to pay attention to all models of health care and campaigns, which worked, and there is no dearth of examples. These need at regional levels both a convergence of social principles and a divergence, which may be necessary for ensuring local acceptability and success. An approach which is united on being:

- Sensitive to unequal relations of power such as class and gender
- Equitable and sustainable in financial terms
- Empowering for individuals in their access to measures for good health

The co-operation includes locating the strategic health issues and situation-solution-seeking in broader approaches eg. of locating HIV/AIDS preventive work, counselling in also existing family planning and welfare centres. The action plan needs to be common to both government and civil society organisations. Solidarity is a critical factor in ensuring success. The co-operation has also to extend between donors and government. Many of these multilateral efforts show up the absence of matching programmes, strategy, financial outlays and exercises for dovetailing. All frameworks need to be jointly moving in the same direction. In the area of basic health needs strategic entry points will need to be determined. In tribal areas the most successful health strategies included livelihood issues, food security, literacy to enable the tribals to access their rights e.g. food provisioning etc. Approximately they fall in the rubric of gender, class and may be judged on the basis of effectivity and accountability. Strategic interests and overall framework cannot be oppositional in character, as is often the case. The state services with their vertical structure need to be interfaced with building horizontal linkages working with dispriveleged groups. Participation is a much-used word but it is not something that can be engineered by funding and policy determinations alone. Few donors even seriously consider financing people's linkages and evolving approaches, which embody principles and approach all stakeholders. Effecting changes, which are visible, is a challenge. If we wish to take it there is little time left. The field conditions must recall to us the unfinished agendas of existence, well-beingness, and the central ethical tenets of caring for others. Health must not be perceived as an economic good and a private privilege alone. All social forces involved in health

in the next millennium may wish to pledge and act on a principle which functions by inclusion and not by exclusion. Health is a social claim and unless we pinpoint the gaps and the structural imbalances we cannot create those dimensions which will carry forward the necessary transformatory processes. ■

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7 The Foundation for Research in Community Health - A Case History

N.H. Antia

FRCH was established as a no-profit voluntary organization in 1975. Its aim was to study why neither the public nor the private health sector could provide appropriate health and medical care to the vast majority of our people whether the poor, middle class or rich. This despite vast increase in manpower, infrastructure and financial inputs. From its inception, FRCH held certain basic premises viz. 1) that health was a fundamental right of the Indian people and 2) health and medical function should be undertaken by people themselves with appropriate support from professionals. It additionally possessed the vision to distinguish illness care from health, which is determined by non-medical factors such as education, sanitation, environment, culture and economics.

The experience in a medical college and its hospital in the city of Mumbai revealed that almost half the patients who sought help were residents of a nearby locality. This unnecessarily swamped the expensive services of this specialized institution for minor day to day problems. It was also noted that even many of the patients who came from distant parts of the state and country for specialized medical care could have been treated adequately in their own taluka or district hospital. Many of the specialized medical or surgical problems like

leprosy and burns could also be treated in a far simpler, humane and cost-effective manner if the available knowledge and technology were modified to suit our people's and country's requirements rather than merely following the 'latest' trends of the West.

If this was the state of affairs in a premier medical institution of our country, the question arose as to what prevailed at the grassroot level where the majority of these problems actually originated. The Preventive and Social Medicine Departments failed to provide any viable answers. Hence, a couple of years were initially spent in observing the health problems of a typical rural area of the Konkan in the North Alibag taluka across the harbour of this premier city. Observations during weekend rambles in the villages and of the local public and private medical services revealed that the major problem was poverty and its associated diseases. The public sector primary health centre hardly provided any of the preventive, promotive and curative functions, while the private practitioners provided unnecessary and even dangerous medication and injections even for simple ailments like flu and diarrhoea, based on the profit motive. Despite being overloaded with work, a couple of motivated MBBS doctors at the District hospital provided a remarkably efficient medical as well as surgical care with the limited facilities at their disposal.

Not knowing the underlying cause nor having the ability to alleviate the poverty, the initial effort was to see if the simple, cheap, safe yet highly effective available remedies for some if not most of these common diseases could be utilized by the people themselves. Since 70% of the population consisted of women and children and the majority of health problems affected them, thirty women, one from each village of about a 1000 population, were provided this knowledge and technology by a small team of social and medical workers supported by a very modest referral service. To our surprise within 5 years these women were able to achieve many of the 'targets' set by the Government for 2000 AD in the late 70's. Besides minor ailments, this included major problems like diarrhoea, dysentery, malaria, tuberculosis, leprosy and even family planning. This helped us to overcome our confusion between education and intelligence of semiliterate and even illiterate women. This opened a new avenue for providing medical services at remarkably low cost. If simple, safe and effective knowledge and technology was provided in a simple manner, village women with their inherent social skills, intimate contact and high credibility within their own community could be the best agents for catering to the medical problems affecting their community leaving relatively few problems for professionally trained doctors of the private and public sectors. The women were also informed as

to when and how to use the available referral services.

As a result of this dramatic experience, FRCH was invited by the late J.P.Naik in 1978 to provide the research component and secretariat for the ICSSR/ICMR report 'Health for All: An Alternative Strategy'. This provided FRCH a unique opportunity to interact with some of the most eminent doctors and social scientists of our country and discuss the possibility of utilizing such a decentralized people based alternative model of health and medical care which differed radically from the existing public as well as private sectors. This also introduced FRCH to a new dimension for the study of health rather than mere medical technology namely the social, cultural, political and economic factors, which underlie both health as well as medical care. This unique Report also stated that over 95% of all health as well as medical care can be best undertaken at the 100,000 population (taluka/block) level, of which 80% could be within the villages themselves. Nevertheless, this people based health care system would have to wait till the right political climate (such as Panchayati Raj) would provide them the necessary power to implement what was within their capability and self-interest.

The 80's were hence spent by FRCH in arriving at a better understanding of the difficulties and problems of the then existing health and medical systems. A series of conceptual as well as field research studies were undertaken to understand the social, cultural, political, economic as well as medical aspects that affected both health and medical care. This included interaction with the ICMR, ICSSR, and Ministry of Health and Family Welfare as well as with other NGOs, national and international agencies including those nearer home like Ralegan Siddhi. Within this period the key contributions of FRCH included a) influencing the adoption of the Community Health Worker's scheme b) compiling a profile of health care in India inclusive of health structure, infrastructure, medical education, expenditure and outlay on health and family welfare in various states c) preparation of health education materials for grass-root level workers and non formal health education schemes d) analysis of medical and public health in several countries e) utilization of tuberculosis as a disease model for advocating a new people oriented approach to control of major infections. Many of these findings earned an international reputation and formed a basis for what was to follow.

It must be mentioned that a unique advantage enjoyed by FRCH in such socio-medical studies was the availability and close interaction with its sister institution, the Foundation for Medical Research (FMR) a well-equipped research laboratory. Both these institutions working as an almost single unit provided a unique opportunity to bridge the traditional

distance between the laboratory and the field for problems like leprosy, tuberculosis, diarrhoeal diseases and reproductive health problems which can be best tackled only through a combined medical and social science research oriented approach. The publications and joint activities that ensued during the 80s and 90s bear testimony to an otherwise much neglected approach to health and medical care, currently followed more systematically and with vigour.

With the advent of Panchayati Raj as a result of the enactment of the 73rd Constitutional Amendment, the major attention of FRCH in the 90s has moved to the understanding of the implications of a decentralized form of governance in the implementation of various alternative strategies for the development of the People's Sector especially in health which is one of the subjects covered under Panchayati Raj. This has enabled FRCH to formulate a more detailed theoretical model based with the help of practical experience gained in a five-year field operational research study in a valley in Purandhar taluka of Pune district. In a carefully documented study covering a population of 17,000 amongst 13-Gram Panchayats, seventy village women have been trained in a wider concept of health than at Mandwa covering several aspects of rural development. Several of these women have in turn demonstrated their ability to train women from different parts of the country sent by organizations who also desire to undertake similar work at the grassroot level. FRCH and its village functionaries have also helped in spreading this model in two districts of Maharashtra as part of a WHO supported project.

FRCH is now imparting upgraded training for some of these village health functionaries to help bridge the gap between the village and the available professional services at the tertiary level such as the taluka hospital and health center. Termed as 'Sahyoginis' they are being trained to provide in turn training, support and referrals to about 25 village functionaries who will work with each of them as a team at about the 5000-population level. This field study has demonstrated the feasibility of an alternative people's sector in both health and medical care which has several advantages over the existing public and private sectors. Such a decentralised people's sector can provide a more accessible, personalized and cost-effective service, which is accountable directly to the community of which it is a part.

Such a Community Health Care System also has several other advantages. These include involving the community in its own health rather than depending on an external service to be 'delivered' by an impersonal public and profit-oriented private sectors. Since the majority of the staff consist of local village women functionaries, it offers the potential for large-scale useful employment of village

women within their own villages, being a field which is highly labour intensive.

- All this at a salary far lower than the excessively paid staff of a unionized bureaucratic top-down public health service subject to targets and transfers.
- Another major gain lies in the demystification of medicine enabling more effective control and use of both the public and private sectors.
- Prevention resulting from intensive non-formal health education, together with early detection, can reduce both suffering as well as the cost of health and medical care.
- Above all, this provides a remarkably effective means for empowering women within their own communities.
- This would enable the people to justifiably demand the diversion of public resources from the urban to the rural sector.
- It would also enable them to divert some if not most of their unnecessarily expensive expenditur incurred on the private sector to their own people's sector which operates without the profit-motive.

It is estimated that such a people's health sector can provide an effective health and medical service at about Rs.175 per capita per annum as opposed to Rs.575 presently incurred in the public and private sectors. This could also enable them to provide free health and medical care to the 33% of the population that live below the poverty line and who now have to divert 20% of their meagre household expenditure on inadequate and expensive medical care.

The Community Health Care system hence has the potential of providing a remarkably effective medical care from the village to the people's own Hospital, with specialist services. FRCH now seeks to demonstrate this on a larger countrywide scale.

Being a people's programme it is closely related to Panchayati Raj. For Panchayati Raj itself to take hold, awareness of citizens and the community at large need to be established for inculcation of accountability as well as bringing health into the mainstream of public focus. Hence, production and dissemination of information at grass-root level is a key activity for FRCH for generating a people's health movement as well as a nationwide network for health and health care. Interestingly almost all the 29 subjects covered under the Panchayati Raj enactment impinge on health. One of the activities of FRCH is hence the production and dissemination of information on Panchayati Raj and the 29 subjects covered under it.

In all these efforts, FRCH enjoys the support of a well-established library and documentation center and administration at its office in Pune. There is ongoing collaboration with state and national institutions such at the Indira Gandhi National Open University, National Open School, BAIF, ICMR, ICSSR, the Ministry of Health and Family Welfare, the Planning Commission, and the WHO. ■

8 Downstaging Cancer Cervix – is it an Appropriate Technology to Spearhead Cancer Control Measures

Elizabeth Vallikad

Globally according to the World Health Organisation, cancer cervix is the fifth most common cancer and ranks second among cancers in women. The International Agency for Research in Cancer, Lyons stated that it is the most common malignancy in the female in the Middle South Asian Region and annually worldwide 460,000 women are diagnosed with cancer cervix, of whom 75% live in developing countries. Cancer cervix is thus essentially a third world problem.

The Indian National Cancer Control Programme 1984 observed cancer cervix to be the most common cancer in women. The National Cancer Registry Programme, Indian Council of Medical Research, estimated the annual incidence of gynaecological cancers (cancers of the female genital tract) to be between 31.6 and 41.5 per 100,000 women. The newsletter of the Indian Academy of Cytologists (October 1999), reports that 18 % of the world's cervical cancer occurs in India,

100,000 Indian women develop this disease every year and 80,000 of them die within five years.

At the Department of Gynaecologic Oncology, Kidwai Memorial Institute of Oncology, Bangalore, it was observed that between 1980 and 1986: - cancer cervix formed >40% of female malignancies, 88.47% of gynaecological malignancies and only 0.32% presented for treatment at Stage 0. While majority (84%) were aged between 35 and 65 years; 97% presented with disease that had spread beyond the cervix at the time of diagnosis, and the two most likely reasons for delay in seeking treatment were lack of awareness of the symptoms of the disease (57.6%) and inadequate advice by medical personnel (33.7%). Non-compliance to therapy was 41.95%. These figures are comparable with those reported in the Journal of the Indian Society of Obstetrics and Gynaecology (1961) applicable for 1954 -1958. Prof. Mitra, Chittaranjan Cancer Hospital observed that cancer cervix formed >40% of female malignancies and 88.2% of gynaecological malignancies while Prof. Naidu, Radium Institute and Cancer Hospital, Hyderabad reported that only 0.6% presented for treatment at Stage 0. The age and stage distributions are comparable with those reported in the same journal, by Prof. Paranjothy, Christian Medical College, Vellore.

Thus it would appear that the magnitude of the problem has remained status quo till date and women continue to present for treatment with advanced disease when the outcome of therapy is far from encouraging.

While cervical cytology, the gold standard for cervical cancer screening has been implemented internationally through both organised (Scandinavian countries) and opportunistic (USA) approaches, in India it is still available only as opportunistic screening to women in elite centres of health care usually urban in location. The Indian Council of Medical Research (ICMR) estimated in 1986 that in India even with a 12-fold increase in cytology services only 25% of women at risk could be covered by the year 2000 AD. Implementation of cytology as a screening programme entails the following: personnel be trained to take an adequate sample from the cervix; make a good smear on the slide; fix it satisfactorily; label it to ensure correct identity; preserve it without breakage; transport it to the laboratory without breakage, where it is properly stained; read and reported by adequately trained cytotechnicians; quality control of the laboratory is required to avoid false positives and false negatives; timely despatch of the report; that reaches the concerned woman; she should be compliant for the necessary treatment outlined by the programme; at centres that provide proficient colposcopy services,

good pathology services and facilities for treatment and follow-up of pre-malignant lesions of the cervix. The newsletter of the Indian Academy of Cytologists (October 1999) also reports that as 100 million out of 400 million Indian women fall into the age group which require screening, India requires at least 5000 trained technicians if cytology is to be made available for them. It entails at least five million smear tests and 250 detected cases for each case of cervical cancer that is prevented.

While developed countries have been able to use cytology to control cancer cervix by detection of premalignant disease, resource constraints have prevented the implementation of a cytology-screening programme on a nation wide basis in India.

However control of cervical cancer consists of not just prevention and early detection but also decreasing morbidity, decreasing mortality, improving quality of life, palliative care, pain relief and terminal care of women with cancer cervix.

Hence the next alternative in the Indian situation is the indigenous development of a strategy for the early detection of invasive disease i.e. downstaging the disease, which can improve survival and thereby contribute to the control of cancer cervix as the first step in the control of the disease. Such a strategy could also be nationally implemented without much infrastructural investment. It could perhaps serve as a harbinger for the gold standard of cytology.

Thus an operational field research project was undertaken at the Department of Gynaecologic Oncology, Kidwai Memorial Institute of Oncology, Bangalore. The aim was to develop and test a strategy that was simple and replicable so that the health infrastructure could implement and include it as part of their regular work.

Phase I

The Feasibility of Training the Existing Government Health Infrastructure to Deliver this Preventive Health Care Facility

This phase attempted to train women primary health care personnel in both raising women's awareness about cervical cancer and visual inspection in order to detect cervical cancer at an earlier stage. It was designed as a community-based intervention trial and involved villages covered by five primary health centres in Bangalore Rural District. While health education regarding cervical cancer and provision of visual inspection services were provided in all four PHCs, in addition cytology was introduced in two PHCs. A fifth PHC served as a control.

The interventions that took place in four of the five areas included in the study were as follows:

		Area 1	Area 2	Area 3	Area 4
Activities in the field	Health Education	Femail JHV; Male JHV;	Female JHV; Mailej JHV; Block Health Educators	Female JHV; Mailej JHV; Block Health Educators	. Anganwadi worker;Male JHV; Block Health Eductors
	Visual Inspection	Femail JHV;	-	Femail JHV	-
	Cervical Cytology	Male JHV;	LMO	Female JHV	LMO
Activities at the PHC	Visual Inspection	LMO	LMO	LMO	-
	Cervical Cytology	LMO		-	

PHC = Primary Health Centre; JHV = Junior Health Visitor; LMO= Lady Medical Officer

All health personnel who were responsible for doing visual inspection underwent a two-day training wherein they were taught to note the appearance of the cervix (its colour, shape, size, surface, the presence of any discharge or bleeding), and based on their observation decide whether it was normal, abnormal or suspicious of malignancy. They were provided with kits containing a torch, specula, and gloves. All those trained in performing cytology were in addition provided with slides, a slide box, a glass marking pencil and fixative solution. Both groups were taught about the necessary procedure that had to be followed to sterilise both gloves and specula. All health personnel involved in imparting health education underwent a one-day training. A training manual, health education material and appropriate record keeping forms were also provided. The JHV (Junior Health Visitor) could perform the tests at the Primary Health Centre, Primary Health Unit, the village school or at the homes of the women, according to the convenience of the women. No target numbers were set for the JHV or the LMO (Lady Medical Officer) and no incentive was given to the health personnel to perform the test of visual inspection or cytology. Thus the attempt was to develop an approach that could be replicated within the existing health infrastructure.

The referral process and treatment guidelines were as follows:

	Area 1	Area 2	Area 3	Area 4
Femaile JHV	VI result: referral to PHC if cervical abnormalities seen or suspicious of malignancy other wise repeat after one year		VI result: referral to PHC if cervical abnormalities seen or suspicious malignancy	-
LMO	Repeat VI and cervical cytology. Refer to KMIO if suspicious of malignancy other wise treat for infection; if normal repeat after one year	Perform VI and cervical cytology	Repeat VI and refer to KMIO if suspicious of malignancy Perform VI and refer to KMIO if suspicious of malignancy	Perform VI and refer to KMIO if suspicious of malignancy
	Cytology test result: Class I: no action Class II: antibiotics prescribed; Repeat smear: Class III or higher: refer to KMIO	Cytology test result: Class 1: no action Class II: antibiotics prescribed; repeat smear. Class III or higher: refer to KMIO		

VI = Visual Inspection; KMIO = Kidwai Memorial Institute of Oncology

Women who reached KMIO as a result of referral from the PHC, they underwent a repeat visual inspection at the Department of Gynaecologic Oncology. They would, if a lesion was visible then be registered with the Hospital Cancer Registry and receive appropriate treatment or if no lesion was visible, be registered with the Department's Dysplasia Clinic, and undergo further investigations such as Pap smear, colposcopy, etc.

The Department of Gynaecologic Oncology had no active role in the field intervention beyond the initial training input, that is, the Department did not do health education or examinations of the women in the field. However, monitoring the progress of the intervention was undertaken in two ways. The first was through copies of records maintained by the JHVs, LMOs and Anganwadi workers about the women to whom they had imparted health education and/or examined, which were submitted to Department personnel at the monthly PHC meetings. The number of women who were referred to the Department for re-examination and additional testing, and the outcome of referrals were also recorded. Secondly, independent assessment of the field activities were

undertaken by the project staff by re-examination of a sample of women who had been examined, and by tracking down those who were non adherent to the advice that they had been given by the health personnel.

A "Knowledge, Attitude, Practice" (KAP) survey was conducted among a representative sample of women between 30 and 60 years in all five areas at baseline in order to measure changes in levels of awareness. The survey was repeated in the same sample at the end of two years of intervention.

The stage distribution of cases diagnosed in the intervention areas was recorded based on the cases which were referred to KMIO by local health personnel; the stage distribution of cases diagnosed in the control zone was recorded based on cases identified through the hospital and population-based cancer registries and information received from other institutions.

The overall coverage of the intervention was low. The highest proportion of women in the age group of interest reached by health education efforts was in the area where JHVs were responsible only for communicating information on cervical cancer. Attempts were made to re-examine a 10% random sample of women who were classified as having a normal cervix and all women who were classified as having a cervix which was abnormal or suspicious of malignancy in order to examine the accuracy of health workers' visual inspection diagnoses.

Women aged 35-60 years reached by intervention in 24 months was as follows:

	PHC I	PHC II	PHC III	PHC IV
Women reached with health education	344	936	824	131
Women screened by VI in the field *	338(6)	NA	530(294)	NA
Women referred to PHC for screening who in fact were screened**	NA	243	NA	36

* Number in parentheses refers to number of women who refused to be screened by VI
** In PHC II and PHC IV screening was only conducted at the PHC by the LMO; field health workers would refer all women in the age group of interest to whom they gave information on cervical cancer to the PHC for screening.

This study demonstrated the ability of the staff of the Government Health infrastructure to impart health education, perform visual inspection of the cervix and triage its appearance into normal, abnormal and suspicious of malignancy and refer appropriately. However in the interest of increasing the number of women that could be covered by such a programme it became necessary to locate alternate local sources of health education.

This led to Phase II of the study with the involvement of two NGDOs in imparting health awareness.

Phase II

The Feasibility of Working with NGDOs to Downstage Cancer Cervix

Two NGDO's Praxis and ADATS collaborated with the Department of Gynaecologic Oncology, Kidwai Memorial Institute of Oncology, Bangalore.

The details of the activities and the involved personnel were as follows:

		NGDO Area I	NGDO Area II
Activities in the Field	Activities in the Field	Female Junior Visitors (JHV); Visitors (JHV); Male JHV; Block Health Educators; NGO health workers	Female Junior Health Visitor (JHV); Male JHV; Block Health Educators; NGO health workers
Activities at The PHC	Visual Inspection Visual Inspection	Female JHV	Female JHV

All health personnel involved in imparting health education underwent a one-day training and those health personnel involved in visual inspection were trained as in the earlier phase. However, a copy of the record keeping was made available to the NGDO so that they could contribute to reduce non-compliance.

The referral process and treatment guidelines used in both the NGDO areas was as follows:

Female JHV: Visual inspection result: normal: repeat after one year; referral to PHC if cervical abnormalities seen or suspicious of malignancy.

LMO: Repeat / fresh Visual inspection result: normal repeat after one year: abnormal treat for infection; refer to KMIO if malignancy is suspected.

The results of this phase were encouraging as the staff of the health infrastructure could cover a larger number of women. The NGDO delivered health education, convinced women that the test was available at the PHC, that they should avail of the facility and if necessary demand the facility. The government health infrastructure only had to deliver services. More than twice the numbers of women were screened by visual inspection in the two NGDO areas when compared to that in the previous phase.

The number of women age 35-60 years reached by intervention in two NGDO areas in 5 months were as follows:

	Area I	Area II
Women reached with health education	680	1346
Women screened by VI in the field	657	1337
Women referred to PHC for screening who in fact were screened	31	0*

* No LMO available at PHC.

Phases III

The Feasibility of Training the Existing Urban Government Health Infrastructure of Bangalore Urban Agglomorate to Deliver this Preventive Health Care Facility

Phase III looked at the health care facilities in urban areas for early detection of cervical cancer in the urban under-privileged women. The strategy used to promote early detection of cervical cancer in the Bangalore City Corporation (BCC) areas was similar to that attempted in Phase I. The activity consisted of training the BCC health personnel at the field and hospital levels and link these workers with the referral facility and passive monitoring by KMIO team. A KAP survey on cancer cervix in the urban under-privileged women was done to assess the level of awareness in a representative sample of these women.

The training programme consisted of the original training schedule to which the components of AIDS and STDs were added. The kit was provided by BCC and the staff deputed were paid travel and daily allowance by the BCC. The health education material and training manual were provided by the Department of Gynaecologic Oncology.

The KMIO project staff would attend monthly meetings at the BCC and collect referral slips of all those women who received health education or had been examined. A list of all those who reached KMIO after referral by the BCC staff was given to them. The number of women who

were contacted and examined in 24 months was as follows:

Women who were contacted for health education by JHV,	3978
Women who underwent Visual Examination	3976
Women who reached KMIO,	294

The KAP survey of 4275 women revealed that the urban under-privileged women were generally illiterate and were married before the age of 15 years; less than 20% had heard about cancer and less than 10% about cancer cervix. About 70% were interested in undergoing the test. Thus it was felt that by involving the urban NGDOs the coverage could be increased.

Summary of the Experience of Phases I-III

The observations of the three phases are summarised in the following two tables:

	Phase I 24 months	Phase II 5 months	Phase III 24 months
Health Education by NGO	-	1025	-
Health Education by JHV	2104	648	3978
Visual Inspection	1413	629	3976
Refused VI	30	19	2
Normal	1234	443	2667
Abnormal	246	172	1295
Suspicious of malignancy	33	14	14
Reached PHC/UC*	289	-	3976
Reached KMIO	87	42	294

*UC Urban centres

The type of diseases that were diagnosed in the women who reached KMIO during the three phases of the study are enumerated as follows:

	Phase I	Phase II	Phase III
Pre Malignant lesions	5	-	2
IB Ca Cx	1	1	-
IIB	1	3	1
IIIB	3	6	9
Ca Ovary	1	1	2
Ca Endometrium	-	1	2
Benign Tumor	-	-	13
No significant observation	76	30	265

Lessons Learnt

The fundamental issue is empowering the Indian women with knowledge that cancer cervix is preventable, early detection can lead to improved survival, decreased morbidity and mortality and that they should demand the facility for early detection. Initially they would restrict themselves to demanding 'visual inspection' - but with time the demand for cytology will come!

It is an illusion that private enterprise of the 'efficient corporate kind' can replace the existing Government Health Infrastructure – though its state is a reflection of the system of our times! This dormant yet well articulated skeleton needs genetic engineering to deliver this preventive health care!

The role of the NGDO would be that of a 'catalyst' to empower women with knowledge so that they can demand of the infrastructure the facilities that they should receive.

Appropriate referral processes would need to be developed to ensure compliance to the test, to treatment, and follow-up.

Skilful co-ordination would be required to monitor all the mechanisms that would orchestrate such an effort.

Conclusion

"18% of the world's cancer cervix occurs in India; 100,000 Indian women develop this disease every year and 80,000 of them die within five years;" Newsletter of the Indian Academy of Cytologists, October 1999

Perhaps an underestimation, as many women do not reach therapy centres to become a cipher in such statistics – but endure miserable, painful, anonymous and lonely deaths.

A 'scientific debate' has been underway for over two decades about what is appropriate for India, cytology versus visual inspection, sensitivity, specificity, false positives, false negatives etc., without any solution in sight. Is it not yet appropriate to implement the knowledge already available in this country to tackle this painful mode of death of Indian women? Must Indian women continue to die of cancer cervix till cytology and the necessary paraphernalia that must go with it can be made available?

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9 Community Based Approaches to Health Care of Tribal and Rural People

H. Sudarshan

Introduction

Vivekananda Girijana Kalyana Kendra (VGKK) is a voluntary organisation, started in 1981 for the integrated development of Soliga tribal people in B.R.Hills. At present VGKK provides health care to 20,000 tribal population in Yelandur, Chamarajanaga and Kollegal talukas of Chamarajanagar District and Nanjungud Taluks of Mysore District. The tribal people in the area were traditionally dependent on shifting cultivation, hunting and food gathering for their livelihood.

Karuna Trust (KT) another Voluntary organisation affiliated to VGKK is covering the entire population of Yelandur taluka (74,000) and Six-Gram Panchayats (50,000) of T.Narasipura taluka.

In contrast to Institution based health programmes, the Community Based Health Programmes are rooted in the community and ensure community participation. These are people oriented, need based,

decentralised, culturally acceptable and cost-effective health programmes.

Health Infrastructure and Human Resources

VGKK has a well-equipped base hospital at B.R.Hills with an outpatient clinic, laboratory, x-ray, operation theatre and indoor hospital. Karuna Trust has a Primary Health Care at Gumballi, Yelandur Taluka. The health services are delivered through 3-tier structure: Village health workers, Multipurpose health workers and Medical professionals. The strength of VGKK and Karuna Trust are its committed cadre of Health professionals and Health workers.

Health Profile of Soliga Tribal People

Soliga tribal people seems to have lead a healthy life till they were displaced and their traditional sources of livelihood were not taken away by the forest regulation which came into force from 1978. Their major health problems are Sickle Cell Anaemia, Tuberculosis, Pneumonia, Chronic Bronchitis, Snake bites and mauling by bears, Hypertension, STD and HIV are very uncommon. We are yet to find a case of Appendicitis, Colonic cancer or a tribal student with refractive error. The health status of tribal people living within the forests is better than those who have been displaced from the forests.

I. Innovative Health Programmes of VGKK

1. Sickle Cell Amnesia Screening Programme

The Soliga tribal people suffer from Sickle Cell Anaemia. The Soliga population has been systematically screened for Sickle Cell Disease (SCD) & Sickle Cell Trait (SCT). Initially Dr. R.L. Kirk of National University Canberra, Australia, helped us to set up the screening programme. At present 28% of the Soliga tribal people have SCT and 2-3% have SCD.

The SCD patients are treated at our hospital. The clinical manifestations of the SCD in Soliga community are less severe when compared to the SCD patients in Africa. This could be attributed to the high levels of Faetal Haemoglobin in Soliga patients. A Longitudinal study to understand the behaviour of the Sickle Cell gene in the absence of Malaria has been undertaken.

2. Integration of Traditional Medicine

The Soliga tribal people had their own traditional health care system. VGKK has made an in-depth study of their system, documented it and integrated it with Modern System of Medicine. Their knowledge of Herbal Medicines and health practices like conducting deliveries in squatting posture are being promoted.

3. *Training Tribal ANMs*

As the non-tribal ANMs were not staying and working in tribal areas. Tribal girls were selected and trained at Mysore and Madikeri Government ANM Training Centres and then posted to remote tribal areas by creating new sub-centres. These ANMs are more acceptable to the tribal community and they stay in the remote tribal hamlets. This programme is being done in collaboration with the Department of Health and Family Welfare, Government of Karnataka.

4. *Training of House Surgeons from MMC and JSS Medical Colleges*

House surgeons from Mysore Medical College are being posted as part of their Rural Health Training since 1990. Later JSS Medical College also started posting their House Surgeons. During their postings, they are oriented to Tribal and Rural Health programmes.

2. *Innovative Health Programmes of Karuna Trust*

The major health problem in the rural population of Yelandur taluka are Tuberculosis, Epilepsy, Leprosy, Mental Health and Nutritional anaemias.

1. *Community Based Leprosy Control Programmes*

As Yelandur taluka was hyperendemic for Leprosy, Karuna Trust took up the Leprosy Control Programme in 1987. More than 1200 Leprosy patients have been cured of Leprosy (both PB and MB cases) and we are in the Elimination Phase of Leprosy Control Programme. The prevalence of Leprosy has been brought down from 16 per thousand to 0.2 per thousand. Karuna Trust has also taken the responsibility of Rehabilitating all the Leprosy patient with disability.

2. *Community Based Epilepsy Control Programme*

This was started in 1990 in collaboration with Indian Epilepsy Association, Bangalore chapter. Hot Water Epilepsy, which is very common in the Mysore plateau region, is being studied, and patients treated free of cost. Dr. K.S.Mani, a well-known epileptologist has trained Medical Officers and health workers in decentralised cost effective and community-based approach to management of Epilepsy. The prevalence and incidence and the natural course of Epilepsy are being studied. Drug trials with two herbs have also been undertaken.

3. *Community Based Tuberculosis Control Programme*

Tuberculosis control programme was taken up in January 1992. Community based health workers, laboratory technicians and medical officers were trained by National Tuberculosis Institute, Bangalore. Approach of supervised chemotherapy with emphasis on sputum smear positive cases was started in our project even before the

DOTS concept. At present more than 95% of the TB patients are taking full course of treatment and getting completely cured.

4. *Community Based Mental Health Programme*

Community based approach to Mental Health Programme and integration of Mental Health into Primary Health Care was undertaken since 1994. The Medical Officers and Health Workers were trained by psychiatrists from NIMHANS. Emphasis is on early diagnosis and treatment of all psychotics in the talukas.

5. *Community Based Eye Care*

Emphasis is on early diagnosis of cataract cases by health workers and motivating them for cataract surgery. Extra-capsular extraction and IOL surgery is being done at the Operation theatre in B.R. Hills. Two ophthalmologists, Dr. Padma Prabhu and Dr. Vijaya Rao are helping us in this programme. Prevention of blindness by Vit "A" profilaxis and early treatment of eye infection and injuries is also part of the programme.

6. *Community Dental Health Programme*

We are running a Dental Clinic at Yelandur with the help of JSS Dental College. Dental Health Education and treatment of simple dental problems is done by health workers.

7. *Primary Health Centres (PHCs)*

PHC (Gumballi) with three sub-centres covering a population of 12,000 in 14 villages was handed over to Karuna Trust by the Government of Karnataka in July 1996. All the staff for the PHC and sub-centres have been appointed by Karuna Trust. All the aspects of Primary Health Care-preventive, promotive, curative and rehabilitative services are being implemented. All the National Health programmes and Reproductive and Child Health programmes are being implemented effectively. Integration of undertaken. All the health indicators show that the health status of the people in the PHC area has improved substantially.

8. *Community Based Rehabilitation (CBR) Programme*

This Programme was started in 1996. This programme for disabled includes Health and medical rehabilitation, Education, Economic rehabilitation, Awareness Building and community organisation, prevention of disability and nutrition programmes. The special features of the programme are: a) Involvement of Panchayat Raj Institutions b) Empowering persons with disability to organise themselves c) Integration of CBR into Primary Health Care d) To do Action Research in CBR.

9. Diabetes Control Programme

This programme was started with the help of Dr. Munichoodappa and Dr. Prasanna Kumar. We are collaborating in a research programme to study the prevalence and incidence of Diabetes in rural and tribal areas. We are also starting the Diabetes Control Programme for the entire population of Yelandur Taluka.

10. WHO & GOI Sponsored Pilot Project at T. Narasipur

A pilot project on "Empowerment of Rural Poor in Health" has been undertaken in collaboration WHO and Ministry of Health, Government of India. Through Participatory Rural Appraisal (PRA) technique, the rural poor are empowered to manage their health by doing Microplanning and formation of Village Health Committees. Both Karuna Trust workers and Government Health Workers are jointly conducting the programme.

10 The Mahila Samakhya Approach to Health and Equity

Revathi Narayanan

About Mahila Samakhya Karnataka...

Mahila Samakhya is a programme of the Department of Education, Ministry of Human Resource Development, Government of India. The programme was born out of the emphasis given in the New Education Policy of 1986 to the need for education programmes to play a "positive, interventionist role" in bringing about women's equality.

MS Objectives:

- To create an environment where women can make informed choices and determine their own destinies.

- To facilitate a process of societal transformation through collective reflection, analysis, learning and action with a gender perspective.

- To enhance women's economic roles by optimum utilisation, redistribution and rejuvenation of community resources.

- To augment women's bargaining powers as members of society by increasing their access and control over household and societal resources.

The MS Strategy

The basic strategy of the programme is the building of village level collectives or "sanghas" that are not merely activity oriented, but which enable women to raise their self-image and confidence and recognise their own strengths. The programme include initiatives in literacy for adult women, non-formal education and creche centres, mahila shikshana kendras for young girls, initiatives for women in health awareness and legal education, participation in local governance bodies of rural women, demanding accountability from mainstream structures and institutions.

MS, Karnataka is today working with about 27,000 women in 1082 villages in 7 districts of Karnataka (Bidar, Bijapur, Mysore, Raichur, Gulbarga, Bellary and Koppal).

Sangha women are taking up a range of health issues to address health and equity concerns. In each sanghas, 2 or 3 women are selected as the health committee by the group. From ensuring that women's ailments are recognised, to discussing the impact of frequent child bearing and child marriage on women's health, to demanding better service from the Primary Health Centre – sangha women are working to foreground women's health concerns.

A recent initiative in MS Karnataka has been a large-scale training of sangha health committee members as rural health leaders. 431 women from 164 sanghas acquired a holistic and gender sensitive information base on the following topics

1. Listing by the participants, of diseases related to women
2. The definition and the importance of healthcare
3. Women and nutrition
4. Community participation
5. Women and the issues of water and sanitation
6. Malaria and TB
7. Gender and self esteem
8. Adolescence and the changes it brings.
9. Physiology of menstruation and conception
10. Conception and pregnancy
11. Childbirth
12. Reproductive tract infections in women
13. Abortion infertility, sex determination and cancers
14. Family planning

15. Menopause
16. Women and violence
17. Mental health and women
18. Women's health and panchayat raj
19. Women and their access to the government health facilities
20. Women's work and health

Some Reactions from the Women

"Our ancestors never had to suffer poverty like we do. There was always enough basic foodstuff and milk in the house. Milk was never sold outside the house. It was for the family's consumption".

"So many greens are available, we can eat everyday, but we have grown too lazy to pluck and cook it. We are beginning to see the impact of lifestyle on the diet".

There was a marked interest expressed by the women on the issue of building toilets. Unfortunately their past experience has been negative "whenever we ask for toilets to be constructed, there is no proper response from the concerned officials. So we had to run from pillar to post. Also, there are often technical difficulties..how deep should the pit be, what material is most suitable.. Added to all this, the entire system is corrupt".

"We have to train and teach our children that all children should be treated equally, whether boys or girls. In particular, we must encourage our girls to find their freedom and identity".

"'Don't go to the temple during this time'. How many times we have been told. I have now understood clearly all the myths attached to menstruation, this training has helped me to separate the facts from the myths".

"Until now, we always blamed the women for the problem of infertility, now we understand the role of the man. May be with the new information, we can prevent second marriages. From now on we will definitely send both partners to the doctor".

"We have learned the legal procedures to handle the issue of rape and feel much more confident of handling the problem. We can take some precautions. Rather than feeling helpless because of the stigma, talk openly about the problem so that the wrong doer can be caught and punished".

Case studies

- *An interesting thing happened in Bidar when the video on childbirth was being screened. As it was in the open space of the temple, a male pilgrim who was staying there began to watch unobtrusively from the back. Conscious of his presence, the women became uncomfortable and finally requested to him to leave. There were pleasantly surprised when he told them "without* understanding all that you go through during the birth of a child, *we men cannot change our attitudes. The more you share this with us, the more sympathetic we can*

be to your problems". They let him watch the rest of the video!

- *Women of the Hulalhalli sangha in Nanjangud taluk, Mysore district found that the doctors in the Government hospital were taking bribes. When confronted by the women, the doctor said that the money was meant for buying syringes. Women decided to buy the syringes themselves. This episode was shared in the ghataka sabha and women of two sanghas decided to complain to the DHO about the doctor. They also decided to ask for the were successful in getting a lady doctor in the hospital.*

- *During the health-training programme, the empowerment experienced by women when they acquired knowledge about the female anatomy was quite remarkable. After some initial shyness and hesitation, the health committee members asked to handle the model of the uterus that was being used by the resource person. They have asked for this model so that they can explain to other sangha members. In the Yelapur sangha of Bellary taluk, women were able to prevent a second marriage by giving a scientific explanation of infertility.*

Health as an issue, appeals to most sections of the village community. Armed with information and practical knowledge on health issues, the status of the *sanghas* is considerably enhanced in the eyes of the community. More and more, the *sangha* is being seen as a valuable resource for the community. ■

11 The Community Health Cell

Introduction

The Community Health Cell (CHC), Bangalore, India, is the functional unit of the Society for Community Health Awareness, Research and Action, which was registered in 1991 under the Karnataka Societies Registration Act 17 of 1960, S. No. 44/91-92. Prior to that the CHC functioned for 7 years as a study-reflection-action-experiment, having been initiated in 1984. It has therefore already maintained its viability for 15 years.

The CHC is a professional resource group, rooted in the voluntary sector in India. It promotes and supports community health and public health action, training, research, policy evolution and advocacy, in partnership with non-governmental and governmental agencies and with people's organisations. The CHC attempts to relate local reality and local action to state, national and international health policy and action.

Its understanding of health issues while being inclusive of biomedical dimensions, is strongly based in the social paradigm, which recognises societal, political, economic, cultural and behavioural dimensions that historically influence the health status of people and health services. CHC explicitly stands for the interests of the poor and less powerful sections of society, basing on values of equity and social justice, in the quest towards better health status and improved access to care.

It supports the idea that health is integral to development and uses an empowerment approach in its strategies. It is also sensitive to gender and ecological perspectives and on the need for sustainability and self-reliance in an inter-dependant global and national environment.

CHC sees its primary role in community and public health to strengthen motivation; enhance conceptual clarity; evolve vision, mission and policy strategies; provide continuing education and peer support; undertake interactive participatory research, and develop an active information resource centre.

A small group of professionals and an office administrative team form the core of CHC, supported by an informal voluntary network of over 30 professionals with multi-disciplinary and multi-sectoral expertise. Support and networking with this group occurs at different levels – local, state, regional and national. CHC sees its work not as being project based in the area of public health and health services, but as being a facilitator, catalyst and participant in a process which may be termed an emerging health movement in the country. Much of its work has therefore been open-ended and issue based, generating a collective response.

WHY WE DO WHAT WE DO

A brief situation analysis of health status and health care in India – the context

- India has a population of approximately one billion (17% of the global population) spread over 26 states and 6 union territories, with wide disparities in health status and human development indices. Health care is provided by the government or public sector, voluntary agencies (not-for-profit NGOs), and the private sector (for -profit including general practitioners). Besides Allopathy, a variety of Indian and other systems of medicine are practiced. Folk health traditions, local knowledge systems and practitioners, comprise the people's sector.

- In spite of massive poverty alleviation and development efforts, there are still over 350 million persons below the poverty line, spread all over the country, but primarily in the BIMAROU region (Bihar, Madhya Pradesh, Assam, Rajasthan, Orissa, Uttar Pradesh), and in disadvantaged districts and pockets of other states. India has slipped further down in the Human Development Index from 134 to 139. Inequity is higher in areas with a concentration of indigenous people (scheduled tribes)

and marginalised social groups (dalits / scheduled castes). Women in general, particularly girl children, the urban poor including street children, child labourers and victims of communal and structural violence are important vulnerable groups. Persons suffering with leprosy, tuberculosis, AIDS, disabled persons and the elderly are also priority groups.

- Health service development in the public and private sector has been substantial, though uneven, ill distributed and poorly regulated since Independence in 1947. Excessive focus on bio-medicine and techno-managerial interventions, following international trends and policies, led to investment in costly, high tech, wasteful expenditure on secondary and tertiary care at the cost of primary health care. Due to insufficient political and financial support, the primary health care system initiated after 1947, and further evolved since 'Alma-Ata', is still inadequate, fragmented, of poor quality and inequitous, in terms of access and availability.

- In recent years, the new economic policy, has accentuated earlier trends of liberalisation, globalisation, and privatization. Of particular concern is the corporatisation, transnationalism and commercialisation of medicine and healing processes. This has increased costs of medical and health care, further strengthened market forces, increased corruption and profit-making and worsened the situation of inequity and inequalities in health care, with added burdens of debt and disease on the poor and disadvantaged.

- On the other hand, because of strong democratic traditions and an active 'civil society', voluntary agencies in health care (not-for-profit NGOs) are a large and increasing sector. Inspired by pioneering voluntary health action efforts that moved from institutional to community based approaches in the late 1960s and early 1970s, and further encouraged by the Alma-Ata declaration, to which India was an important contributor, the numbers of voluntary groups involved in community oriented and community based health action have increased substantially.

- Three membership based national coordinating agencies exist in the voluntary sector namely, the Voluntary Health Association of India – a national federation of state level organisations in health care; Catholic Health Association of India and the Christian Medical Association of India. These networks with their members organise annual

meetings, workshops, training and continuing education and provide information updates through regular journals / bulletins.

- Additionally, there are other issue-based networks and groups in the voluntary sector and people's social movements that raise broader issues for advocacy and policy change. Well known among them are the medico friend circle; the All India Drug Action Network, state drug action networks; the All India Peoples Health Tradition Network (LSPSS); All India and State level People's Science Networks and more recently the National Alliance of People's Movements. The latter are increasingly interested in health issues.

- Since the early 1980s, a small number of alternative, multidisciplinary, resource groups emerged in support of grass root groups and movements. They are primarily devoted to evolving community health approaches, participatory training methodologies, networking with field action initiators in the country, moving from micro level action to macro level situation analysis, policy research and advocacy. These groups include the Foundation for Research in Community Health (FRCH) - Mumbai and Pune; Centre for Enquiry into Health and Allied Themes (CEHAT) - Mumbai; Society for Education, Action and Research in Community Health (SEARCH) - Gadchiroli (Maharashtra); Child In Need Institute (CINI) - Calcutta; Action for Research in Community Health (ARCH) - Mangrol (Gujarat); Nucleus for Health Policies & Programmes (NHPP) - New Delhi. Studies done by them are beginning to address and inform health policy.

- Community Health Cell is also one such resource centre. It has established wide linkages with all the groups mentioned above through a strong commitment to interactive research and promoting collective action through networking. It has also worked with a large range of health action initiators. International linkages have included academic centres, such as the - London School of Hygiene and Tropical Medicine [LSHTM], Tropical Child Health Unit - Institute of Child Health, London, Centre for International Health, University of Bergen, International Child Health Unit, University of Uppsala, Sweden, WHO-ICO and Medicus Mundi International. Linkages range across ideological and religious affiliations and have established CHC's credibility as a known community health and health policy centre.

⇨ We are currently in the late 1990s working in a rapidly changing, uncertain and volatile global and national environment. Sudden events such as the nuclear explosion with its ethical and medical implications, sanctions, communal tensions, episodes of social violence, political instability and economic recession have health consequences and often require a response that may not have been planned earlier. This situation is also causing us to think seriously about re-defining the boundaries of public and community health in a context where strong forces are splintering communities apart. It is also our experience that major forces impacting on health are often deeply embedded in social relations. We need to rethink our vision, objectives and strategies in the context of this situation.

Problems of Health Care addressed by the CHC

The current problems of health care, as identified by the Society, are:

- Community health action initiatives of the voluntary sector in India are increasingly becoming top down, vertical packages of selective primary health care interventions, similar to the public sector, focussing on distribution of drugs, vaccines and contraceptives, with the community being involved as passive beneficiaries. With increasing funding for voluntary sector health work coming from governmental and bilateral programmes, NGOs are becoming subcontractors of top down health programmes and are conceptually viewed as alternative service providers. **The community empowerment - organisation - participation dimension crucial to sustained community health action is getting diluted and deemphasized.**

- Education of health personnel in the governmental and voluntary sector is too focussed on technical content with little attention to societal dimensions and educational processes. The emphasis is on 'what' but not adequately on 'how' and 'why'. **Doctors, nurses and health workers are not trained adequately to work 'with communities', but 'for individuals'.**

- The new economic policies with continued emphasis on high-tech bio-medical investigations and medicalised treatment focussed on secondary and tertiary care institutions in the private, corporate sector, is weakening and distorting primary health care system development, and is resulting in a neglect and dystrophy of public health expertise. This

has led to a **continuing breakdown of the public health system in India** leading to the re-emergence of old public health problems like malaria and kalazar, worsening of tuberculosis and an increasing inability to effectively handle newer problems like AIDS and other epidemics of communicable and non-communicable diseases.

- Unchecked growth of the pharmaceutical industry and increasing effects of market forces on drug policies in India, have **continued a distortion in types of drugs manufactured and irrational prescription practices and use among medical professionals and health care providers.** This increases costs of health care, besides subjecting patients to health hazards and economic stress. Amendments of the Indian Patents Act of 1970, under pressure from the WTO, will be a disincentive to and reduce indigenous drug production and pharmaceutical research, increase imports and escalate drug prices with adverse consequences on patients especially the poor.

- The dominance of the Allopathic/ Western system of medical / health care had led to the **increasing marginalisation in planning and organisation of Indian and other systems of medicine and traditional practices** and their continued neglect and lack of involvement in national health strategies.

- While a rich diversity of innovative **approaches, alternative thinking and collective action in health care** and health alternatives have developed in response to the above problems, these are still **inadequately known, or communicated to others** who could benefit from these experiences and ideas. They also do not adequately influence mainstream health policy, planning and practice.

- Finally, despite a growing networking of efforts and the evolution of independent, collective thinking and action in India, international public health packages together with globalisation and international capitalism are further distorting the health situation by topdown vertical selective health care programmes promoted by such partnerships. The preoccupation with project management rather than process facilitation in these efforts; and the increasing evolution of monitoring and evaluation systems are distracting and distorting action at the community / field level. **There is increasing need for dialogue to counter these vertical programmes and convert them into integrated community health services. Horizontal partnerships of different actors**

will be needed to evolve and support this, based on shared learning from local experience.

Strategies to tackle problems

CHC's strategy to counter each of these problems is:

- To promote community health action which enables and empowers communities to tackle health problems and evolve local solutions within a broader poverty eradication context.

- To promote and evolve educational strategies that enhances social and community orientation, process dimensions and approaches in training, especially for doctors and health workers.

- To increase awareness of the crisis and breakdown of the public health system and strengthen collective, multisectoral and multidimensional responses, especially in tackling priority disease problems at their roots.

- To promote rational drug use among health care providers and consumers and to enhance the understanding of rational and essential drug policy issues.

- To promote initiatives towards enhancing the dialogue and linkages between the plurality of Indian and other health systems / traditions and their increasing involvement in community health.

- To promote dissemination of information concerning deeper health situation analysis, problem identification, innovative ideas and approaches.

- To enhance dialogue with funding agencies to promote horizontal partnerships and collaborative efforts to counter distortions of the market economy on health care.

- As is evident, these strategies address underlying societal processes. Their impact can only occur later and be assessed by multi-disciplinary, including ethnographic methods.

What we do

Activities of CHC (refer pamphlet enclosed)

i) **Information and advisory service** through correspondence and personal interactions.

ii) **Training inputs** through five types of participatory programmes.

- Specific thematic sessions in formal training programmes of other voluntary and academic organisations.

- Specific inputs in informal workshops and short-term training programmes of voluntary sector coordinating agencies.

- Specific sessions in training programmes for governmental health personnel.

- Short training courses for community based health workers in collaboration with field based NGOs – on request, focussing on community health, herbal medicine, rational drug use, minor ailment treatment, etc. (in Kannada / Telugu / Tamil / Malayalam). (Requests for (a) to (d) vary annually).

Medical Education – Social Relevance / Community Orientation

iii) **Participatory reflections / review** with NGO teams to improve scope and quality of services, and with groups of NGOs through networking to pull in learning experiences and enhance sharing of ideas and expertise.

iv) **Participatory / Interactive Research and Evaluation** (an important contribution of CHC)

- In 1995 – 97 a Public Policy Analysis Study of the National TB Control Programme in India collected qualitative data from field interviews with TB patients, village leaders, grassroots health workers, and health care providers in government and NGO centres.

- An interactive process pulled in ideas and suggestions from over 50 participants involved in Malaria control issues or action for a VHAI facilitated Independent Assessment on Malaria programme in India.

- Prior to that participatory evaluations have been done of field NGOs e.g., (KSSS, RTU, etc.) training centres (e.g., ISI); and national agencies (e.g. CHAI).

v) **Peer group support** – A unique feature of CHC's activities is to provide time for reflection and dialogue with individuals searching for greater social relevance in their health work or in evolving and planning new ideas and approaches. These partners come from very diverse backgrounds and disciplines.

vi) **Networking** – CHC is an active member and/or a resource group to many networks in the country – national and state level. In solidarity, it is also actively involved with

governance of groups such as the Voluntary Health Association of Karnataka, International Services Association-Bangalore, Drug Action Forum -Karnataka, and Advisory Committees of FRCH-Mumbai and other resource groups supporting Health Action. Team members are resource persons for the Asian Community Health Action Network (ACHAN), founder members of WHO-ICO's new International Poverty and Health Network and Associate Members of the International Network of Community Oriented Health Sciences Institutions.

Partnerships and Collaboration

Historical ties with the Voluntary Sector

- CHC has worked closely with CHAI, CMAI and VHAI on various collaborative projects including facilitating workshops, interactive research and evaluation and supporting learning through networking around issues at a national level and regularly contributing to all the three journals - Health For the Millions, Health Action and Christian Medical Journal of India.

- It has linkages with CHAI-Karnataka unit, VHA-Karnataka, CMAI - Southern Region office in Bangalore and Drug Action Forum-Karnataka providing resource persons for their training programmes and workshops.

- It has been an active member of the mfc, a founder member of AIDAN and DAF-K and a resource group for LSPSS, AIPSN and other networks.

- CHC has been supported by European funding agencies like Misereor - Germany, Cebemo/ Bilance and Memisa - Netherlands; Oxfam - UK. It has been actively involved in horizontal dialogue and has been a resource group for partnership review and evaluation. It has worked with EZE, BFW, Action Aid and others as a resource group.

Newer Mainstream Linkages

- In Bangalore, with the National Institute of Advanced Studies, Institute for Social and Economic Change, National Law School of India, St. John's Medical College, Rajiv Gandhi University of Health Sciences, Community Medicine departments of medical colleges, etc.

- In India, with the Ministry of Health and Family Welfare, Indira Gandhi National Open University, Medical Council of India, Indian Council of Medical Research.

Strengths & Weaknesses Analysis of CHC - 1998 Review

(Refer to Review Proceedings for overall findings)

- The strengths of CHC identified by the 1998 Review included its values and work ethos, responsiveness to need, the social paradigm, networking, multi-disciplinary approach, non-hierarchical and participatory team functioning, flexibility, financial transparency, secular nature, perspectives deriving from Indian experience and a good library / information centre.

- Its weaknesses included shortage of professional personnel in respect to the demands of work, a resultant excessive work load, problem of time management because of open ended approach, conflicts between catalyst role and taking responsibility, inadequate efforts towards self reliance in financial and human resources, pressure on the team due to short notice, excessive freedom and flexibility.

Steps are being taken to address some of the weaknesses and threats.

Post Review Changes at CHC

The shifts that are occurring are:

a) **An explicit commitment to equity and empowerment in its work.**

b) Moving from open-ended catalyst interventions **to more proactive, focussed, definitive and sustained work on areas** in which it has developed experience and expertise. These include:

   i. promoting community health based on a social paradigm,

   ii. human resource development, particularly medical education of doctors and training of community level health workers,

   iii. rational therapeutics and rational drug policy, including the issue of patents,

   iv. Indian and other systems of medicine, particularly the integration of local health traditions and practitioners into community health,

   v. crisis in the public health system affecting infectious diseases such as malaria, TB, HIV/AIDS and other national programmes concerning priority health problems,

vi. health policy issues particularly those concerning implementation, and the influence of international agencies and policies on national health policy and practice,

vii. women's health and gender issues.

Emerging areas of interest and work are:

i. Poverty and health linkages,

ii. Medical and public health ethics.

A community health and public health approach will be utilised in tackling the above issues. Efforts will be made to strengthen and enhance public health policy action.

- Moving from voluntary sector focus to **mainstreaming**, that is being inclusive of the larger health care sector, such as strengthening of the public sector, universities / educational centres, challenging and engaging with the private sector and supporting movements that are pro-poor.

- Shifting from plural networking to developing **strategic links** with groups and individuals who are equity **and empowerment oriented** i.e., there will be an explicit focus on people and regions in poverty and need.

- **Developing appropriate organisational mechanisms, structures and linkages** required to make the above changes, including developing leadership and expanding the core team of professionals with persons who share values, vision, critical thinking and who function democratically. The ethos and values of CHC as identified by the Review will be retained and nurtured in this change process of evolution over the next few years into a Centre for Community Health and Health Policy, that will build on Indian experience.

Post Review Activities

Proactive measures have been taken to undertake follow-up work in areas of CHC's research studies and involvements and enhance their policy process dimensions.

1) Medical Education

- Interaction with the Parliamentary Sub-Committee on Medical Education included making submissions and participating in meetings.

- Interaction with (including giving reports to) the Medical Council of

India regarding internship, with the Indian Medical Association regarding postgraduate education, with the Indian Council of Medical Research regarding medical ethics concerning experimentation on human subjects.

- Work with the Rajiv Gandhi University of Health Sciences to which all-medical colleges and colleges of allied health professionals in Karnataka State are affiliated. A 2-day workshop on the Challenges of Management in Medical Education was organised for the Deans of all medical colleges. A note on the introduction of Rational Therapeutics and Rational Drug Policy was accepted. Another 2-day workshop on Medical Ethics is planned in March 1999. A few medical colleges have subsequently been in touch for inputs concerning medical education cells, research methodology workshops, drug policy etc.

2) *Follow-up of work with CHAI*

- Helped with planning and production of special issue of Health Action on WHO; joined Editorial Board; sent other material and suggestions.

- Was resource person for National Consultation of Regional Units and Stakeholders Meeting.

- Agreed to Review Comprehensive Plan, for which initial work has started.

- Participation and support to CHAI – Karnataka's {CHAIKA} activities - CHAI day meetings, AIDS action, District Health Action Forum.

- Helped to plan and participated in a South Bihar Health Policy Workshop with CHA – Bihar.

New Thrusts

i) Responding to local public health issues

➪ **Dengue Fever** - organised meetings and catalysed small research studies concerning the problem in Bangalore through a local medical college and governmental agencies.

➪ **Hepatitis B vaccine** - organised meetings, collection of reference material and a press conference (with Drug Action Forum - Karnataka (DAF-K) and Environment Support Group) regarding the irrational way in which Hepatitis B vaccination camps are being organised in the city and elsewhere. The State Health Minister has now constituted a Committee to go into this.

➪ **Amendments to the Patents Act (1970)** - With DAF-K, organised a meeting, supporting further public debate on this issue as the long-term implications to the consumer/ patient, particularly the poor will be immense.

➪ **TB** - This will be taken up in 1999-2000, but in the meantime, micro-inputs into 2 NGO's and discussions with CHAI, CMAI, VHAI and several people have been held. Also

1. Paper on "*Educational Approaches in Tuberculosis Control: Building on the 'Social' Paradigm*" written for a book titled "Tuberculosis – An Interdisciplinary Perspective", edited by Dr. John Grange and Dr. John Porter, published by Imperial College Press.

2. Paper entitled "A *Violation of Citizens Rights: The Role of the Health Sector, particularly of the State Health and Related Services, in regard to Tuberculosis in India*" presented at an International Conference in Mumbai, organised by CEHAT.

3. Meeting with European donor agencies on HIV & TB and the need for increased support.

4. Policy meeting at NTI with national and state policy managers, World Bank, WHO & DFID.

5. Karnataka State TB Association meeting

➪ **Malaria** - Participated in facilitating a coalition of citizens groups and different levels of government (local / State / ICMR) to respond to problems in Mangalore City of Karnataka – gave professional inputs through a series of meetings and visits.

- Gave resource inputs at **WHO-SEARO** meeting on Roll-Back Malaria.

- Requested to help set up a National Task Force on Social Science Research in Malaria.

Continuation of 1997-98 initiatives

i) WHO and International Poverty and Health Network (IPHN)

Responded to Draft Policy Document of the new WHO-DG

- Conducted and collated responses to an email questionnaire from IHPN members on the Draft Document.

- SOCHARA Vice-President and three members suggested by us, including Catholic Health Association of India, participated in the IPHN meeting in Kisumu, Kenya.

- RN participated in a meeting on "Regenerating Public Health" organised by WHO and King's Fund in London.

- Planning for November 1999 dialogue in Bangalore hosted by CHC on South Asian Perspectives on Poverty and Health.

ii) Women and Health

- Attended meetings called by Ministry of Health, Government of India.

- Agreed to coordinate training of 2000 grassroot women leaders (mahila sangha and gram panchayat members) in 5 districts of Karnataka during 1999-2000 through State and District level resource groups, involving NGO's and Government. Preliminary discussions/ preparations are being held regarding this. Prepared two and part of a third module (on TB, malaria and rational health care) for Training cum Information Pack being produced by a national core group of which we are members.

Current Key Initiatives

◆ Working towards initiatives for a People's Health Parliament (Jana Swasthya Sabha) to be held at a national level in Calcutta and the People's Health Assembly at an international level, in Dhaka, in November/ December 2000 - as member of state, national and international coordinating group

◆ Participation in the Karnataka Task Force on Health - set up by Government of Karnataka to evolve a plan for promoting primary health care and public health with a focus on equity and quality.

◆ Collaboration with Government of Karnataka as a Technical Resource group to evolve an integrated and comprehensive health nutrition and population programme for the state.

How We Can Work Together —

☛ If you are planning Community Health action and would like to reflect on your plans with peers; undertake preliminary project visits, study tours or electives; do some background reading or prepare for action in any other way - please contact us.

☛ If you are involved in Community Health action, service, training, research and issue raising, and need information or advice, support with planning, training, review and evaluation - please contact us.

- If you are involved in Development, Education, Organization, Conscientization, Lobbying, Communications or Journalism, and are interested in exploring Community Health and/or Health Policy issues - please contact us.

- If you would like to participate in our activities and attend the Community Health Forum meetings or be kept on our mailing list - please contact us.

How you can Support us

- If you would like to support our work technically, please put us on your mailing list to receive papers / books / articles.

- If you would like to support our work financially, you could contribute

  i. By providing a regular annual contribution of Rs. 500/- ($50) or more and qualify to be a Friend of CHC.

  ii. By a donation of any amount to the Society's corpus fund.

[As a Friend, you will be kept on our regular mailing list and kept informed about all aspects of our work.]

NOTE: All donations by Cheque / draft / MO should be made in the name of The Society for Community Health Awareness, Research and Action or S.O.C.H..A.R.A or Community Health Cell.

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Section III

Health Financing

12 The State and Health Services: the Worm's Eye-View of Health Care

A. Indira and Vinod Vyasulu

When one speaks of health, it is often a large hospital that comes to mind. But health is more than the absence of illness: it is a state of positive well being. It is thus an intricate system of institutions that are needed for providing medical/health care. It is primarily a state's responsibility, if we go by the directive Principles of State Policy in our Constitution-to provide medical/health facilities to all citizens. In this regard, much has been done in terms of focussing on preventive and public health, and encouraging public participation. The private sector[1] in different forms has played a major role. This because in India today, the state alone cannot fulfil all the varied health needs of the people.

As a precursor to all these medical initiatives, a document "Health for All" was brought out in 1972 in Alma-Ata. In India, a joint ICSSR-ICMR committee[2] provided a framework for health policy. Its focus was on (1). Preventive and public health, and (2). Public participation

1 People have been spending considerable amounts on health—as shown by the research of T.N. Krishnan, under the UNDP sponsored research programme.

2 Chairman: V. Ramalingaswami, then Director General of Health in the Government of India.

in health care. These were in particular the responsibility of the state—in India, the government.

We in this paper are trying to bring across our findings in the health sector based on an earlier study[3]. All findings are based on public funds being spent on this sector in Karnataka. We focus on the district, which is an administrative unit well understood in India. And with the passing of the 73rd amendment, the district has also become a tier of self-government below the state level. All this was done to ensure, enable, and encourage public participation-an important element of policy. What has happened since on the ground?

Karnataka has under the aegis of the Department of Health, implemented programmes on priority areas such as provision of health services to ensure primary health care, implementation of programmes for control of leprosy, malaria, blindness, filaria, and introduction of specialized services. It has also provided extra inputs like staff equipment to teaching hospitals, supply of stand-by generators, grant-in-aid to autonomous institutions, providing specialized treatment to diseases like cancer, mental health, cardiology, trauma care centre, construction of buildings for health institutions.

In the area of family planning, it has sought to provide additional incentives for the implementation of family welfare programmes, maternal care and child health, and implementation of a specialized area programme. Development of other systems of medicine like-Ayurveda, Siddha, Naturopathy, Yoga through establishment of health institutions and development of medical education in these areas has also been encouraged.

The other related issues that have been tackled are formulation and implementation programmes relating to enforcement of various central drugs and cosmetics acts; analysis of drugs, training of pharmacists and conducting post-graduated courses in pharmacy. The government has also established and is maintaining hospitals and dispensaries to cater to the medical needs of the insured persons under the employee's state Insurance scheme. All of the above are some of the major areas where the Plan programmes are formulated and implemented in this sector.

3 A study on devolution of budgetary finances focussed on the health sector as one of its issues. The functioning of the local governments vis-à-vis the departments was also analyzed. For details, one can see A. Indira, et al, Democracy and Decentralisation; A Study of Local Budgets in Two Districts of Karnataka", Centre for Budget and Policy Analysis, Bangalore, March, 2000.

Health expenditure is a large component of the state budget. In this state, health budgets have grown, but very slowly over a period. Also *it is generally presumed that the access to medical care has been on an average good*. People from the interior rural areas coming to the city for better medical facilities is not considered contradictory to the original intention of having good facilities at the local levels. The HDI data show that health is still poor-whether we use life expectancy at birth or the infant mortality rate[4].

We in this paper are trying to focus attention on how the health sector has fared in the budgets of various years at the district level. To understand health in its entirety one should consider family welfare, women and child welfare, medical and public health services, together with water supply and sanitation, and related nutritional data—so many departments are involved. Here we deal only with the department of medical and public health, without forming any linkages between the other departments. We confine our comments to one district: Dharwad. The paper largely draws from a recent study of local finances we have been working on[5]. These limitations should be mentioned at the outset.

The paper is organised as follows: Section 1brings to fore the various issues of how health has fared at the state level. Section 2shows the numbers that are allocated and expended through the budgets of the local self-governments. Section 3 brings out the anomalies within the framework of public participation through the local self-governments and the Department of Health.

Dharwad is one of the larger districts, which was divided into three for easier administrative purposes[6] in 1997. It is a district, which is considered as a fairly well managed district. Geographically it is a dry district. It also has a history of strong cooperative movements. The common man here is known to be more aware than in the rest of the state.

The data used here is for the older district of 17 taluks. Data for family welfare and women and child welfare is also shared here for having an understanding of how the budgeting is done under the various heads. The bulk of the health expenditures

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4 Vinod Vyasulu and B.P. Vani, "Development and Deprivation at the district level: A Study in Karnataka" Economic and Political Weekly, November 1997; Government of Karnataka, Planning Department, Human Development in Karnataka, 1999.

5 A Indira, Democracy and Decentralisation: A Study of Local Budgets in Two districts of Karnataka, CBPS, Bangalore March 2000.

6 Vinod Vyasulu, "The Economy of Dharwad: The Traverse to Development", IDPMS, 1997.

is made under medical and public health which shows the various systems of medicine, and the various health services. Family welfare has been a centrally sponsored scheme for a long time and continues to do so for obvious reasons. As for women and child welfare, the aspects of pre and antenatal care, immunisation progammes are shown under this head.

Table No.1

Health Care Indicators in Dharwad: Government Sector										
Talukas	Total Popul- ('oos) (excl HDMC)	# of Govt. Hos- pitals	#of Beds	PHCs	#of Beds	PHUs	Dispen- saries	Family welfare Centres	Sub Centres	Medical Stores
Dharwad	1928	1	180	6	36		3	2	43	151
Hubli	1131	1	750	5	30	1	2	4	33	375
Kalghatgi	1213	1	30	4	24	1	2		28	7
Kundgol	1380	1	30	4	24	1			32	19
Navalgund	1615	1	30	5	30		4		34	23
Total	**7267**	**5**	**1020**	**24**	**144**	**3**	**11**	**6**	**170**	**575**

The above table gives secondary data for the new Dharwad having five taluks. These figures show how the medical system is working. From the above table, one can see that each of the taluks have only one government hospital each. The total number of beds for the five taluks is 1020 for a total population of nearly 7.5 lakhs. The medical stores are 575 in number. These numbers are indicative of the facilities available for curative systems. In this system, there are no indicators of public and community health.

We next take a look at the macro level, the moneys allotted and spent for the district has a whole. It is seen that the share in the total allocation for women and children welfare is 2%, about 2% for family welfare and 6% in medical and public health (table 1). These figures are fluctuating over the years.

Table No. 2

Share of both Total (Plan + Non-Plan) to the total Allocation Towards the District for Individual Sector. (Figures in Percentages)			
Years	Medical & Public health	Family welfare	WCW
1987-88	5.11	2.64	2.16
1988-89	5.31	2.67	2.15
1989-90	7.20	3.17	2.11
1990-91	6.27	2.54	2.13
1991-92	6.15	2.58	2.09
1992-93	7.41	2.47	1.99
1993-94	7.67	1.84	1.86
1994-95	6.38	2.18	2.46
1995-96	5.91	1.94	2.28

WCW: Women and Children welfare
Source: Annual accounts and audit reports (Dharwad). The figure for each sector is a sum of capital and revenue accounts only.

Table No. 3

Share of both Total (Plan + Non-Plan) to the Total Expenditure Towards the District for Individual Sector. (Figures in Percentages)			
Years	Medical & Public health	Family welfare	WCW
1987-88	4.96	2.29	2.05
1988-89	4.88	2.02	1.72
1989-90	5.81	2.04	1.72
1990-91	5.55	2.02	1.79
1991-92	6.00	2.20	1.77
1992-93	6.56	1.86	1.94
1993-94	5.79	1.86	1.96
1994-95	6.24	1.93	2.28
1995-96	6.30	1.91	2.33

WCW: Women and Children welfare.
Source: Annual accounts and audit reports (Dharwad). The figures for each sector are a sum of capital and revenue accounts only.

When we compare the total expenditures with the total allocations (tables 1 & 2), we see that for medical and public health, though allocations are fluctuating, expenditure has risen from 4.96% in 1987-88 to 6.3% in 1995-96. The same can be said about women and children welfare. Under family welfare, allocations and expenditures are nearly matching.

Coming to within the sector, for the shares between plan and non-plan heads, we see that most schemes have a Plan and Non-Plan component. As a matter of principle, most Plan heads are transferred to the Non-Plan head after five years. The general philosophy being that by this period the programme taken up in Plan can stand on its own.

From table 4 we see that, Medical and Public Health: most of it is under Non-Plan, but this is fluctuating and showing a rather random fall from 85% in 1987-88 to 74% in 1995-96. The Plan head on the other hand is steadily increasing from 14% in 1987-88 to 28% in 1995-96. Under family welfare, one can see that it has been a Plan component from many years-100%, and continues to be so. Looking at the women and children welfare (WCW) or social security and welfare as it is here in this district, one sees that in both Plan and Non-Plan the shares are small, infact negligible for some years like 1993-94 onwards where the Non-Plan allocations have fallen below 1%. But for the corresponding Plan allocations it has steadily risen, showing 4% growth in 1995-96.

Table No. 4

Share of Plan to Non-Plan Allocation for each Sector
(Figures in Percentages)

	Medical & Public health		Family welfare		WCW	
Years	**Non-Plan**	**Plan**	**Non-Plan**	**Plan**	**Non-Plan**	**Plan**
1987-88	85.75	14.25	0.00	100.00	1.63	2.93
1988-89	77.23	22.77	0.00	100.00	1.22	3.71
1989-90	85.48	14.52	0.00	100.00	1.22	3.86
1990-91	82.15	17.85	0.00	100.00	1.22	3.51
1991-92	83.95	16.05	0.00	100.00	1.13	3.75
1992-93	73.88	26.12	0.00	100.00	1.02	3.67
1993-94	69.73	30.27	0.00	100.00	0.99	3.33
1994-95	71.32	28.68	0.00	100.00	0.97	4.49
1995-96	74.38	25.62	0.00	100.00	0.89	4.07

WCW: Women and Children Welfare.
Source: Annual accounts and audit reports (Dharwad). The figures for each sector are a sum of capital and revenue accounts only.

The women and children welfare schemes come under the head of social security and welfare. For easier identification we have put the numbers under the head — women and children welfare here.

The tables 3 & 4 show the ratio of Plan to Non-Plan under each of the social sector heads considered here in the study for the Dharwad district. These figures have been put together from the macro table got from the Accountant General's audit reports for all sectors. Here the sectors are mentioned only macro headwise.

Table No. 5

Share of Plan to Non-Plan Expenditure for each Sector (Figures in Percentages of Total District Expenditure)						
	Medical & Public Health		Family Welfare		WCW	
Years	Non-Plan	Plan	Non-Plan	Plan	Non-Plan	Plan
1987-88	91.09	8.91	0.15	99.85	53.18	46.82
1988-89	78.69	21.31	0.00	100.00	36.06	63.94
1989-90	84.41	15.59	0.00	100.00	37.26	62.74
1990-91	81.15	18.85	0.00	100.00	36.76	63.24
1991-92	84.64	15.36	0.00	100.00	33.89	66.11
1992-93	71.07	28.93	0.00	100.00	29.23	70.77
1993-94	81.33	18.67	0.00	100.00	24.99	75.01
1994-95	74.96	25.04	0.00	100.00	23.71	76.29
1995-96	74.80	25.20	0.00	100.00	18.32	81.68

WCW: Women and Child welfare.
Source: Annual accounts and audit reports (Dharwad). The figures for each sector are a sum of capital and revenue accounts only.

So far as medical and public health is concerned the Non-Plan expenditure has declined from 91% in 1987 to 78% in 1988, has again risen and fallen to settle at 75% in the last two years of 1994-95 and 1995-96. The Plan expenditure has increased proportionately on the other hand. There is a now a 75:25 ratio, between Non-Plan and Plan. Family welfare has been Plan expenditure throughout. In the sector Women and Children welfare, Plan expenditures have risen over the study period from 46% in 1987-88 to whopping 81% in 1995-96. Correspondingly, Non-Plan has dropped drastically to 18% in 1995-96 from a share of 53% in 1987-88.

Now let's move to the actual figures spent on health from the district budget documents. These have been compiled from the link documents [a part of the government's budget papers presented to the Assembly]— this gives us the allocations made to any district every year

and the audited ZP statements giving the expended figures.

The heads under medical and public health can be broadly divided between medical services taking into account various systems of medicines namely, Allopathy, Homeopathy, Ayurveda and Unani.

It is interesting to note that most expenses and allocations are seen under the Allopathy head. The other heads concerning other systems of medicines and nature cure are not really well protected in the budget. Not much money is allocated towards these heads. This came out quite clearly even in our field survey, where when we asked the most widely practiced system, majority said that it was Allopathy. This should be probed in depth.

We have clubbed the different health systems to get an aggregate picture. Majority of the money is spent under Allopathy and hence the different heads under services provided has a large component of Allopathy only. In other words, one can take it that Allopathy is more prevalent than other systems. Both Plan and non-Plan are clubbed together to get an aggregate picture of the major heads.

The Urban health services also come under the Zilla panchayat budgets. This is because the taluk headquarters have a reasonable population in semi-urban and urban areas, but falling under ZP limits and not the Town Municipal Corporations.

Public health services include such services as awareness creating among public on issues like TB, cancer etc. these are also moneys spent towards the preventive and community health services.

Table No. 6

Share of Allocations towards the Major Heads (Plan and Non-Plan together). (Figures in Percentages)

Years	Urban Health	Rural Health	Public Health
1987-88	21.25	59.87	18.88
1988-89	20.29	60.16	19.55
1989-90	32.63	52.78	14.58
1990-91	26.35	56.30	17.34
1991-92	24.27	61.40	14.33
1992-93	24.38	61.79	13.83
1993-94	21.55	65.15	13.30
1994-95	21.78	64.12	14.10

Source: compiled from our data sheet

The allocation table 5 shows that the ranking of priority health schemes follow the rural health, urban health, and public health schemes. In case of urban health during 1987 to 1989 and 1993 to 1994, the share has remained around 20 percent. The set of schemes that include the urban health allocation are- the establishment and maintenance of health institutions at urban areas i.e. hospitals and hospitals attached to teaching institutions.

In the case of rural health services, the share has been above 55% throughout except in 1989-90, which was around 52%. And one can also notice a yearly increase of 4 to 5% over a period of time. This may indicate an expansion of medical institutions in the rural district.

However, it is crucial to note that the schemes relating to public health are gaining increasingly less attention during our period of study. Infact there is a sharp decline from almost 20% in 1987 to 14% in 1995. There could be a hidden message that curative services are gaining more importance than preventive, and community health care. This matter requires a probe by experts in this field.

Table No. 7

Share of Expenditures Towards the Major Heads (Plan and Non-Plan together). (Figures in Percentages)

Years	Urban Health	Rural Health	Public Health
1987-88	22.36	53.62	24.01
1988-89	26.95	56.67	16.38
1989-90	23.42	61.19	15.39
1990-91	23.69	60.13	16.19
1991-92	22.97	61.70	15.33
1992-93	22.91	63.71	13.38
1993-94	21.67	63.33	14.99
1994-95	20.58	64.86	14.57

Source: compiled from our data sheet of expenditure figures culled from the ZP office.

So far as expenditures are concerned the expenditure on schemes relating to rural health services have increased from 53% in 1987 to 65% in 1995 which is almost 10% in 8 years period. And the expenditures on Public health have come down by almost the same proportion. This may also indicate that there may have been an internal shift of priorities in the health sector, which is seen in allocating the money towards these heads (table 5).

Table No. 8

Share of Plan Non-Plan to Total Expenditures (Figures in Percentages)		
Years	**Plan**	**Non-Plan**
1987-88	19.74	80.26
1988-89	21.02	78.98
1989-90	15.62	84.38
1990-91	18.76	81.24
1991-92	15.33	84.67
1992-93	28.88	71.12
1993-94	17.11	82.89
1994-95	25.01	74.99

Source: compiled from our data sheet.

The share of Plan expenditure shows fluctuations over a period of 8 years. There is an all time increase of 29% in 1992-93. As a typical scenario, the share of non-Plan continues to be more in health sector also. There is a clean divide of 75:25 in favour of Non-Plan.

It is clear from data for total allocation and total expenditure on health sector, that growth of allocations and expenditures under plan head is more erratic than under non-plan. Also expenditures have always lagged behind the allocations made.

From compiled data, we combined the heads to understand the per capita expenditures under the various services. Accordingly, we see that under rural health services plan head comprising of amounts spent towards buildings etc., the per capita figures are as low as 0.35 paise in 1987-88 and rising to 0.58 paise in 1994-95. The allocations are not any higher than these figures. When we consider the moneys spent on rural health services, non-Plan, we see that the per capita figures in the latest year of 1994-95 shows an allocated sum of Rs 2.67 and Rs 2.61 of expenditure.

Under urban health services, the expenditures have grown over the years. But still the differences between the allocations and expenditures are quite high. The reasons need to be explored. Allocations have shown a drop in the last few years from 1992-93 onwards, when the current prices are deflated and seen. However, allocations have grown at 8%, while expenditures have shown only 4% growth. Similarly under non-plan heads, for urban health services per capita allocation is Rs 1 or less than that per year,

of course the expended amount being even lesser.

Training head appears only under Non-Plan. We can see the dismal picture. On an average, less than five paise per capita is being spent in the study period. Also even in nominal term, allocations have barely been sustained; in real terms they have fallen, and expenditures are even less.

Under public health services-prevention mainly, when we look under control of diseases, Plan amounts are very much less compared to Non-Plan sums. Under Non-Plan there is some matching between allocations and expenditures, while under Plan, allocations have not seen fully spent. In 1994-95, per person Rs 2.12 was allotted which was spent fully. The tables show that there are no Plan schemes taken up newly. All are mainly under Non-Plan, which probably means salary and maintenance only. This may be checked.

Coming to individual Schemes, we see some interesting trends. Here we reproduce a few interesting tables to gain some insights.

About Primary Health Centres

Here we can get a general idea about the Primary health centers, we use three tables given below. These schemes come under rural health services - Allopathy.

Table No. 9

Primary Health Centres (GOI Pattern) (MNP). (2210-03-103-0-71) (Plan) (Figures in Lakhs)					
	Current prices			Constant Prices	
Year	Allocation	Expenditure	Deflators	Allocation	Expenditure
1987-88	18.33	19.10	370.3	4.95	5.16
1988-89	30.50	28.63	409.7	7.44	6.99
1989-90	30.50	38.49	438.3	6.96	8.78
1990-91	45.18	48.14	460.9	9.80	10.44
1991-92	51.25	50.19	460.3	11.13	10.90
1992-93	50.00	47.21	483.5	10.34	9.76
1993-94	70.00	59.24	513.0	13.65	11.55
1994-95	80.00	77.76	552.7	14.47	14.07
Growth Rate	20.22	19.18		14.35	13.36

Source: Data sheet compiled scheme wise

In the above table, we can see both the allocations as well as the expenditures are increasing every year. Though there is a fluctuation in the expenses, it has always been closer to the allocations. The growth in expenditures has kept pace with allocation at 13% and 14% respectively. This does not however give us an idea of how the Doctors, ANMs, Nurses are posted and how their services are qualified. That needs follow up by panchayats, NGOs, Citizens, researchers and others.

Table No. 10

Upgradation of Primary Health Centres (PHC) (4210-02-103-1-02) (Plan) (Figures in Lakhs)					
	Current prices			Constant Prices	
Year	Allocation	Expenditure	Deflators	Allocation	Expenditure
1987-88	22.00	20.53	370.3	5.94	5.54
1988-89	8.00	18.30	409.7	1.95	4.47
1989-90	4.00	43.33	438.3	0.91	9.89
1990-91	9.00	11.97	460.9	1.95	2.60
1991-92	30.00	17.65	460.3	6.52	3.83
1992-93	30.00	24.28	483.5	6.20	5.02
1993-94	60.00		513.0	11.70	0.00
1994-95	25.00	13.17	552.7	4.52	2.38
Growth Rate	1.61	-5.40		-3.36	-10.02

Source: Data sheet compiled scheme wise

Under Rural Health services, we can see from the table (9) that from 1990-91 onwards the allocations have increased. In the table we can see in the year, 1993-94 there is no expenses met against Rs 60.00 Lakhs. How could this be? It needs scrutiny.

Though in the earlier years the expenditures were more, the allotted amount was very less. Against an amount of Rs 4.00 Lakhs Rs 43.33 Lakhs has been spent in the year 1989-90. But for each of the above heads, one sees that allocation in the recent years (from 1990-91 onwards) has been higher than the expenditures. There is a gap, which means that the entire allotted sum has not been spent. Given the common belief that there is not enough money for many things to be done at this level—we often hear both the public and the officials bemoaning the lack of money for undertaking work—this is a surprising finding. The reasons for this have to be sought separately.

The growth rates for both allocations and expenditures are negative. It is sad to note that the allocations and expenditures have not kept pace with the growing needs of the local environment. There are random changes in the figures, which show that no new plan schemes have been implemented.

Table No. 11

Upgrading of Primary Health Centres. (2210-03-103-0-73) (Non-Plan) (Figures in Lakhs)					
	Current prices			Constant Prices	
Year	Allocation	Expenditure	Deflators	Allocation	Expenditure
1987-88	0.72	6.35	370.30	0.19	1.71
1988-89	0.50	0.83	409.70	0.12	0.20
1989-90	0.98	1.07	438.30	0.22	0.24
1990-91	0.79	0.58	460.90	0.17	0.13
1991-92	0.89	0.91	460.30	0.19	0.20
1992-93	1.53	1.09	483.50	0.32	0.22
1993-94	1.61	2.84	513.00	0.31	0.55
1994-95	1.65	1.72	552.70	0.30	0.31
Growth Rate	10.92	-15.06		5.88	-19.22

Source: Data sheet compiled scheme wise

Under upgrading of Primary Health centres (table 10) though an amount of Rs 6.35 Lakhs has been spent in the year 1987-88 against an allocation of 0.72 lakhs, it has gone down in the latter years.

The Non-Plan figures show that here too the expenditures have fallen far below the allotted sums. The growth in allocations is a minimal of 6% and this can utamost keep in par with inflationary pressures. Expenditures show proper growth when compared to allocations. The difference between allocation and expenditure needs a probe. Such a large difference makes a mockery of the budget process.

The following tables are a reflection of how moneys flow towards prevention and control of diseases.

Table No. 12

Other Diseases – Guinea Worm Eradication Programme (2210-06-101-7-06) (Plan) (Figures in Lakhs)					
	Current prices			Constant Prices	
Year	Allocation	Expenditure	Deflators	Allocation	Expenditure
1987-88	0.08	0.14	370.3	0.02	0.04
1988-89	0.09	0.07	409.7	0.02	0.02
1989-90	0.09	0.07	438.3	0.02	0.02
1990-91	0.15	0.14	460.9	0.03	0.03
1991-92	0.20	0.11	460.3	0.04	0.02
1992-93	0.20	0.05	483.5	0.04	0.01
1993-94	0.05	0.10	513.0	0.01	0.02
1994-95	0.10	0.04	552.7	0.02	0.01
Growth Rate	2.83	-14.50		0.00	-15.91

Source: Data sheet compiled scheme wise

Table No. 13

Blindness - National Programme for Prevention of Blindness (2210-06-101-8-01) (Plan) (Figures in Lakhs)					
	Current prices			Constant Prices	
Year	Allocation	Expenditure	Deflators	Allocation	Expenditure
1987-88	0.53	6.28	370.3	0.14	1.70
1988-89	4.38	3.52	409.7	1.07	0.86
1989-90	4.82	3.15	438.3	1.10	0.72
1990-91	8.23	3.30	460.9	1.79	0.72
1991-92	2.00	1.58	460.3	0.43	0.34
1992-93	2.25	2.27	483.5	0.47	0.47
1993-94	2.50	3.29	513.0	0.49	0.64
1994-95	3.85	3.54	552.7	0.70	0.64
Growth Rate	28.13	-6.91		22.28	-11.50

Source: Data sheet compiled scheme wise

Table No. 14

Leprosy-Leprosy Control Scheme. (2210-06-101-4-04) (Plan) (Figures in Lakhs)					
	Current prices			Constant Prices	
Year	Allocation	Expenditure	Deflators	Allocation	Expenditure
1987-88	8.20	12.55	370.3	2.21	3.39
1988-89	12.69	10.60	409.7	3.10	2.59
1989-90	13.89	10.12	438.3	3.17	2.31
1990-91	15.70	11.35	460.9	3.41	2.46
1991-92	14.85	10.77	460.3	3.23	2.34
1992-93	16.40	10.50	483.5	3.39	2.17
1993-94	16.40	8.29	513.0	3.20	1.62
1994-95	18.00	14.07	552.7	3.26	2.55
Growth Rate	**10.33**	**1.44**		**4.98**	**-3.50**

Source: Data sheet compiled scheme wise

Table No. 15

Leprosy Control Centres. (2210-06-101-4-02) (Non-Plan) (Figures in Lakhs)					
	Current prices			Constant Prices	
Year	Allocation	Expenditure	Deflators	Allocation	Expenditure
1987-88	2.72	10.78	370.30	0.73	2.91
1988-89	8.06	4.94	409.70	1.97	1.21
1989-90	4.96	6.51	438.30	1.13	1.49
1990-91	5.82	6.36	460.90	1.26	1.38
1991-92	4.78	4.09	460.30	1.04	0.89
1992-93	6.74	4.37	483.50	1.39	0.90
1993-94	8.84	5.52	513.00	1.72	1.08
1994-95	7.26	5.77	552.70	1.31	1.04
Growth Rate	**13.06**	**-7.52**		**7.58**	**-12.07**

Source: Data sheet compiled scheme wise

Under Leprosy Control Schemes (Non-Plan) we can see that there is full utilization of the money being allotted. Under the Leprosy Control scheme (table 14), we can see there are fluctuations in allocating the amount. But in the case of expenditures we can see that the expenses are more than the allocations in the years 1989-90 and 1990-91 (it has increased around Rs 6.5 Lakhs) and in later years we can see that it has decreased.

Table No. 16

Leprosy Control Scheme (CSS). (2210-06-101-4-05) (Non-Plan) (Figures in Lakhs)					
	Current prices			Constant Prices	
Year	Allocation	Expenditure	Deflators	Allocation	Expenditure
1987-88			370.30		
1988-89	16.81	10.16	409.70	4.10	2.48
1989-90	14.50	16.13	438.30	3.31	3.68
1990-91	18.10	13.58	460.90	3.93	2.95
1991-92	21.04	19.03	460.30	4.57	4.13
1992-93	23.48	22.51	483.50	4.86	4.65
1993-94	28.58	27.03	513.00	5.57	5.27
1994-95	28.51	27.69	552.70	5.16	5.01
Growth Rate	7.84	15.40		3.34	10.57

Source: Data sheet compiled scheme wise

In the above tables (11,12,13,14,15), one can see that more allocation are made to Leprosy control scheme and Prevention of blindness than for the prevention of Naru hunnina roga. Though more allocations have been made available for eradication of leprosy and the blindness, it has not been used to the full extent. There is always fluctuations in the expenses from the beginning years. But under the eradication of blindness in the later three years (i.e. from 1992-93 to 1994-95), the expenses are more than the allocations. Though once in the year 1990-91 the allocations have touched Rs 8.23 Lakhs it has come down in the following years. But in the case of prevention programme of Naru hunnina roga both the expenditures as well as the allocations are very less. The above three schemes were centrally sponsored schemes till 1989-90 after which it became state sponsored schemes. It is at this level decisions are taken and not at the district level.

We understand that the schemes are fixed and are spent as committed expenditures. There is no flexibility, funds cannot be shifted from one scheme to another.

Under Non-Plan, however the data show a greater flow of funds under each of the heads. The system of Allopathy has been given a better standing than the other systems of medicine. The work under this system has also been divided between urban and rural health services.

About Medicines

Here we can see an important component of health services, namely, the timely supply of vital medicines. These are usually sent after the approval of a budget and an indent process for procuring medicines at several local hospitals. Medicines ofcourse are bought in bulk. The list of medicines get approved annually and cannot be altered at a short notice.

The funds supporting medicines and chemicals for hospitals and health sub-centres (table 19) show that the funds have actually fallen over the years. It was as high as Rs.44.3 Lakhs in 1989-90 and 1990-91 and fallen later over the years. It has however again picked up over the year 1994-95 to Rs. 32.05 Lakhs from a low of Rs. 18.51 Lakhs. In real terms, it has been halved. Infact the growth of money spent towards medicines has shown a declining trend, which needs some serious thought. More so because this comes under rural health services - Allopathy which in general is having the largest share. Where is all the money going?

Table No. 17

Medicines & Chemicals for Hospitals & Health Sub-Centres
(2210-03-103-0-74) (Non-Plan)
(Figures in Lakhs)

	Current prices			Constant Prices	
Year	Allocation	Expenditure	Deflators	Allocation	Expenditure
1987-88			370.30		
1988-89			409.70		
1989-90	44.30	41.24	438.30	10.11	9.41
1990-91	44.30	43.67	460.90	9.61	9.47
1991-92	18.51	12.33	460.30	4.02	2.68
1992-93	19.43	23.60	483.50	4.02	4.88
1993-94	29.14	24.30	513.00	5.68	4.74
1994-95	32.05	25.83	552.70	5.80	4.67
Growth Rate	-5.25	-7.50		-8.85	-11.02

Source: Data sheet compiled scheme wise

Table No. 18

Chemical Examination Regional Centres. (2210-06-107-0-02) (Non-Plan) (Figures in Lakhs)					
	Current prices			Constant Prices	
Year	Allocation	Expenditure	Deflators	Allocation	Expenditure
1987-88	2.16	2.37	370.30	0.58	0.64
1988-89	2.77	1.87	409.70	0.68	0.46
1989-90	2.94	1.11	438.30	0.67	0.25
1990-91	3.69	1.99	460.90	0.80	0.43
1991-92	3.52	1.69	460.30	0.76	0.37
1992-93	3.25	1.70	483.50	0.67	0.35
1993-94	2.41	2.36	513.00	0.47	0.46
1994-95	3.00	2.15	552.70	0.54	0.39
Growth Rate	4.19	-1.21		-0.89	-6.00

Source: Data sheet compiled scheme wise

Under the above head Chemical Examination Regional Centres (table 20) one can see that the amount being allotted is not used to full extent, though in the years 1993-94 and 1994-95 it is nearing the allocations. We can see from the table though there was an expenditure of RS 2.37 Lakhs in the year 1987-88 against RS 2.16 Lakhs it has fallen in the later years. Even under the allocations, there is always a fluctuation in the grant.

This table infact reflects the poor diagnostic setups in our rural areas. The numbers speak for themselves. What is the quality of service being provided? Under Plan head, infact there is no equivalent scheme! It seems there is no plan to have services in any new setup, and the existing services are so bad.

Family Welfare in Dharwad

Family welfare expenditures are direct central government expenditure towards family planning programmes.

Table No. 19

Share of Allocation from state and Centre (Plan) (Figures in Percentages)		
Years	SSS	CSS
1987-88	3.39	96.61
1988-89	2.90	97.10
1989-90	2.90	97.10
1990-91	4.46	95.54
1991-92	4.40	95.60
1992-93	4.45	95.55
1993-94	6.22	93.78
1994-95	4.58	95.42

Source: compiled from our data sheet.

Table No. 20

Share of Expenditure from State and Centre (Plan) (Figures in Percentages)		
Years	SSS	CSS
1987-88	4.52	95.48
1988-89	0.00	100.00
1989-90	3.45	96.55
1990-91	3.29	96.71
1991-92	2.62	97.38
1992-93	0.70	99.30
1993-94	1.14	98.86
1994-95	0.79	99.21

Source: compiled from our data sheet

Family Welfare sector has been under Plan account throughout. From the tables it is obvious that states responsibility has been less than 5% with 1 or 2% fluctuations, where as the Central Government is the controlling authority so far as finances are concerned. The estimates for family welfare programme are sent by the state Government to the Government of India. Since the schemes are Centrally Sponsored schemes even if a particular ZP fails to send its expenditure estimates, the state Government is expected to provide funds even to the defaulting ZPs for the purpose of family welfare programme. Since it is a priority programme, the State Government

diverts funds from other programmes to family welfare programmes of the ZPs. Though ultimately the state Government may get reimbursement from the Government of India, the states own priorities in health sector may suffer to that extent due to diversion of funds in the initial stages. The Zilla panchayats do not seem to play any other role in this. What does public participation then mean?

We next take up the Women and Child Department which is administratively distinct from the Health Department and has different budget lines. The work it does is central to public health. The issue of improving local governance in important sector must take into consideration these issues. The discussion becomes critical when one realises that most of these sectors come under Departments, which go back a long time. They have administrative procedures, their own resources and practices. Has the present day brought any change in the working styles when different systems have to come together, integrate new methodologies and grow further? As of now, it has still not been able to get integrated into the new system of local governance. This comes out clearly in the discussion that follows.

Karnataka was the first state in the country to implement the panchayat raj system, as envisaged under Art.40 of the Constitution. The 1983 Act brought into force the two-tier system of Zilla Parishad and Mandal Panchayats. A total of 29 departments were transferred from the State to the ZPs. The officials were deputed to work under the ZP administration. The first phase of the PRIs was between the years 1987-1992. In the year 1993, the 73rd Amendment came into effect and the incumbent state government brought an amended 1993 Act into force. This brought a few changes in terms of three-tier system. The main important one being the institutionalisation of Grama Sabha and the Grama Panchayats. The earlier arrangement of the departments coming under ZP continued with a few changes, namely, a less rigorous one. The actual action on field where revenues are earned, project proposals formed, beneficiaries selected are all done at the GP level.

There are four kinds of schemes, state sponsored, central sponsored, state sector and central sector schemes. These are devolved to the district. At the ZP level, again there are ZP, TP and GP schemes. These various schemes are plans that are continuously monitored and implemented by the authorities.

The structure is as follows: The head of the ZP is the President. The Vice-President comes under him. The CEO is deputed from the state government and helps in administration. Previously in the 1983 act, the elected representatives handled much of the administrative details. The ZP president was all-powerful, equivalent to a State minister. He wrote the confidential

report of the CEO. However now, under the 1993 A ct this has been changed. The CEO's Administrative Head is the Secretary, Rural Development and Panchayat Raj. The CR of CEO is also written by the Secretary.

Various officers work under the CEO. The exact structure varies between different districts. Much is dependent on the size of the district. The main officers are Chief Account's officer, from the State Accounts department, the Chief Planning officer from the State Planning department. The Deputy Secretaries I and II can be junior KAS officers. The Council Secretary and the various sector district heads coming from the various State departments like Health, Education, and the Engineering divisions. The CAO has under him two Accounts officers, one for Budget and scheme, and the other-compilation and audit. The CPO has a Project appraisal and evaluation officer who in turn has a statistical officer working under him. All these officers are deputed from the State government and can be transferred from one ZP to another. There is no fixed tenure post for these functionaries.

Below this level of officers at the ZP level, the TP hierarchy starts. The head of the TP on the official side is the Executive officer, (the BDO in the earlier regime). He has a similar organizational structure working under him. The CR of the EO is written by DS-I. But the EO is answerable to all the officials who are in charge of works implementation at the ZP level. The CAO can also directly deal with him for all accounts presented. Similarly so for the relation between the EO and the various sector district heads, who are in charge of the various sector departments. The EO has to coordinate with all of them.

At the next lower level, the GP Secretary is the government functionary. He is answerable to the higher authorities at both the TP and ZP levels. He assists the GP members.

What comes out clearly is that the various official functionaries, if need be can run the government without bringing into picture the elected people. How does this happen? There is a parallel structure between the officials and the elected bodies. Though the Act tries to bridge the two, one can see a subtle 'dyarchy' in the system both with respect to the governmental relationship between state and ZP functions which is run by functionaries as also the elected bodies and the ZP officials.[7] Flowchart 3 shows this clearly.

7 In our interviews with various secretaries of the sectors (Department heads), we had an interesting revelation that the younger generation of officers were ignorant of any vision of PRI that was to be sustained. Whereas the senior bureaucrats said that work had progressed along the thinking envisaged in the early days. They do not talk of any retrogression in PRI functioning or speak in terms of an existence of 'dyarchy'. They said the State had the best working model of PRIs in the country and they were fine-tuning the system.

Every constituency (at the GP level — which is generally made of 4-5 villages) has one PHC on an average, which is not sufficient to attend to the problems of the local people. The major concern of the representatives in the district is non-availability of sufficient doctors and ANMs in the primary health centers. Most of them complain about the irregular attendance of the duty doctors. Consequently, the people are forced to consult the private doctors available in and around their constituencies. The kinds of services that are offered at the PHCs are vaccination and immunization. One has to travel on an average 10 kms for higher medical care.

There are a good number of private doctors practicing even in under developed constituencies. Allopathy is found to be the popular kind of medicine in both the districts. It came to light that the local governments have no say about the kind of medicines required in the PHCs. Most programs and schemes are designed and finalized at the State level.

Of the total ZP funds, only 7% is spent on health through ZP, all the rest are directly spent by the department itself. There are many weaknesses in the Scheme where the local elected body cannot decide appointments, kind of medicine, or service required. We also find that the decision making process gives no role to the local elected bodies in the department, so the aspect of public participation has nothing to do with all this.

The information discussed above was collected over a period of two years, and that too in a district which is reasonably well-informed and the information systems are kept in order. In the same period, in the other district studied Bangalore rural we could not progress much, because of two main reasons. One, indifference on the part of the ZP and two, lack of systemised data at the ZP level itself. The total allocation and total expenditure of Health sector in this district shows that the non-plan moneys are more than plan. However, one can also see that in general the amounts are also smaller compared to Dharwad. This district is organised differently from Dharwad. This sector in this district at the ZP level has only the salary component. Data for development works taken up comes under each division which has administrative jurisdiction for four taluks.

From the above discussions it may be concluded that:

1. System of medicine: Allopathy is more popular than other systems

2. Services provided: the amounts spent on public health services is declining over a period of time.

3. Role of local self-governments: there is little interaction between the local elected body and the departmental officials.

4. Poor maintenance of data at the district level. ■

13 Health Care Cooperatives (HCC): An Alternative Organizational Mechanism for Health Care Delivery for the Poor

P.R. Panchamukhi

The present paper has the following objectives:

i. To briefly outline the effects of some of the economic reforms which are likely to be unfavourable from the point of view of the health care needs of the poor. In the background of this discussion we present a case for a different organizational mechanism for meeting the health care needs of the poor. This would provide an empirical rationale for the suggested organizational mechanism.

ii. To present a conceptual rationale for the suggested mechanism.

iii. And finally, to raise some issues for trying out the idea about the suggested mechanism.

Economic Reforms and Health Care Needs of the Poor

In the course of economic reforms many sectors are likely to be affected – some favourably, some less favourably and some would have mixed experiences. Health sector is likely to belong to the third category. While liberalization and attraction of foreign direct investment in the health care sector are likely to attract new knowledge and technology relevant for the modern health care services, this is also likely to allow the entry of new life styles particularly of the materialist would in connection with the health care services. The vast population of the country (more than 40 percent of 100 crores) may not be in a position to afford the high costs associated with this new life style of modern health care services. Following the cue from the high priced imported drugs of post reform health care delivery system, the indigenous drug manufacturers also might raise their drug prices. This is evident from the increased prices of most of the Ayurvedic and Homeopathic drugs also during the 90's. A systematic study of drug prices during the recent period is being initiated in the Centre.

The general ethos of economic reforms is one of increasing withdrawal of the government from the non-economic sectors in particular. This is also brought out from the empirical studies for different countries, which have adopted the economic reforms. A systematically documented study bringing out the changes in the index of governmental involvement in different sectors during the economic reform period in different countries is also being initiated in the Centre. In this background, ***the incidence of lower governmental participation in health care services, is likely to fall on the less privileged sections of population.*** It is also noticed that in course of economic reforms, the union government has adopted the strategy of assisting the states more through loans rather than grants even for the sub sectors of the social sector. Obviously, this would mean additional debt burden on the state governments, which, therefore may not be very enthusiastic to receive the Central assistance, particularly for the non-economic sectors, which do not have tangible financial returns. Hence, the health sector may have to face the impingement of the adverse consequences of this new strategy of Central assistance. ***This in turn, would affect the health care interests of the less privileged sections of population.***

After bringing medical profession under the purview of the Consumer Protection Act, the medical test syndrome for all types of ailments seems to have caught up. This

also has resulted in increased costs of medical care services, ***the incidence of which would be highly iniquitous for the less privileged sections of population in particular.***

On the whole, the economic reforms are likely to have less favourable effects on the health care service supply so far as the less privileged sections of population are concerned.

In this background, ***there is a need to have a new institutional structure for health care delivery, which is responsive to the low ability to pay of the poor in the developing countries***. In fact, the high costs of medical care are found to have made significant inroads into the economic conditions of the less privileged households. This may be termed ***as immiserization of the poor due to the forces from health care sector.*** The new institutional mechanism has to explicitly take note of this process of immiserization of the poor.

Currently, the health care delivery system consisting of private sector institutions and the public sector institution like PHC, government hospitals, etc., seem to 'follow the peculiar variant of 'accepted sequence', to use the term of Dr.J.K.Galbraith, in supplying the medical care services. In other words, they wait till the affected and vulnerable people actually approach the health care delivery system for the purpose of health and medical care services. When the 'revised sequence' is adopted, it follows a stereotype methodology of supplying the package of health care services, as determined at the headquarters of the supplier viz., the government department of health. Most often, the package may not be consistent with the real needs of the people. This would be evident from a close study of the functioning of PHC's in the Indian context. From our preliminary study of the minutes of the Village Health Committee (VHC) in some of the villages in Dharwad district, we noticed that the required health care components, as recorded in the minutes of VHC meetings, are not included at all in the programmes as implemented by DHO. They do not have any connection with the schemes as determined by the Directorate of Health Services for the state. This only goes to show ***the wedge between the real needs of the people, demands as articulated by a section of the population and the schemes in health care services which are actually implemented.*** This dichotomy is obviously at the cost of the health care needs of the less privileged sections of population. This suggests the need for an institutional structure which is highly responsive to the ***health care requirements of the poor and less privileged population groups, particularly in the rural areas.***

Thus, an innovative organizational mechanism, which is sensitive to the health care needs and the ability to pay of the less privileged sections of population, is required in the post reform situation in the developing countries in general and in India in particular.

The ***Health Care Cooperative*** is visualized as such an innovative organizational mechanism for the health care delivery.

The above paragraphs have attempted to provide ***an empirical rationale for the Health Care Cooperative.***

Philosophical basis for the Health Care Cooperative

Recent changes in the lifestyle of the economy like India, are thus likely to pose special health problems for the poor, calling for urgent countervailing measures in order to safeguard their interests. Any such measure which is based upon the principle of equal treatment of unequals or unequal treatment of equals would not lead to equality in the ultimate analysis. The new measures should be based upon ***equal treatment of equals*** leading to horizontal equity and also upon ***unequal treatment of unequals*** lending to ***vertical equity.*** While discussing the issues about health care of the poor, mere considerations of 'equality' would not be adequate. What is required is the consideration of equity. Here too, the conventional principles of equity, as outlined above, need to be redefined. For example, if equality coefficient is defined as relative access and utilization of a particular population group in proportion to its relative strength in total population, then the objective of equality/ equity might be satisfied but, the goal of justice in access and utilization of health care for the poor might not be. What is required is 'more than equal treatment of equals and unequal treatment of unequals'. In the background of economic reforms such an approach is needed and the suggested mechanism of health care cooperatives might serve this purpose.

According to Adam Smith, human behaviour is guided by six springs of human conduct, such as, self-love, desire to be free, propensity to truck, barter and exchange, habit of labour, sense of propriety and sympathy (Theory of Moral Sentiments). Unfortunately, the economic science has not paid adequate attention to the human behaviour under the sixth spring of human conduct viz., sympathy. Adam Smith has a full chapter entitled 'On the. Pleasure of Mutual Sympathy' indicating the human action guided by the concern and consideration for others. In some societies, there is a strong religious basis for sympathy in general and mutual

sympathy in particular. In the Indian context, the religious ethos provides a powerful sanction for this spring of human conduct. Family as an institution has survived in India, primarily on account of this ethos itself. Family can be considered as a powerful cooperative, operating on the ethos of sympathy and mutual sympathy. This also appears to be the least cost mechanism of delivery of various services, irrespective of the ability to pay of the members of the cooperative. The principle of 'for each according to the need and from each according to the ability' seems to be the basis for the functioning of the family as a service cooperative.

So far as health care services are concerned, the family has acted in the past as an effective health care cooperative, with the grandma's maturity in diagnosing and treating the common ailments of the members of the family.

Family as a health care cooperative suggests certain basic principles for extending the idea of cooperative to a larger number of families or a cluster of villages.

The following principles seem to suggest themselves in this connection.

i. The health care needs of every member have to be closely monitored and met.

ii. The supply of health care to the members is not incumbent upon their payment.

iii. The internal resources of health care need to be fully mobilized for catering to the needs of the members.

iv. Those who have ability to pay should make payment of costs of the health care of all the members of the family.

v. The contribution to the health care services may not necessarily be in terms of cash only. It can also be in kind, say in terms of services by those who are capable of making this contribution.

vi. Larger the number of members of the family greater the capability of the family to meet the health care needs of the members, for, the contributions both in cash and kind are likely to be adequate in such a situation. The resources of maturity and knowledge, which are crucial in the case of health care services, might also be a positive function of the size of the 'family'.

vii. There seems to be an optimum family size for the purpose of cost-effective supply of health care services, at the

most desired supply levels and standards.

viii. The neighbourhood benefits accrue to the family in a closely networked social system operating on the principle of 'pleasure of mutual sympathy'.

ix. Family as a health cooperative can have better bargaining strength if the health care services have to be borrowed or bought from outside the family. This is because the other families in the neighbourhood are likely to be affected by the force of reciprocity and hence, they might willingly contribute their services in the situations of need. Similarly, the external sources of supply of health care services may also have to take cognizance of the family rather than an individual as the demander of services. In this case, the responses of the source of supply of the service would be more amenable and less expensive (?) than when the individual/s confront the source of supply.

x. Taking care of the siblings and other dependents when elder members of the family have to undergo medical treatment is better facilitated in the context of the health cooperative of family.

Thus, there are interesting aspects of family as the health care cooperative, which can be borrowed while designing a ***cluster of families in the villages as a Health Care Cooperative (HCC).***

Major Questions

The questions that need to be answered at the outset are the following:

i. What is the optimum size of a HCC?

ii. How to implement the idea of cross subsidization of costs of health care services in HCC?

iii. Apart from medical care, can HCC be an effective mechanism for the supply of public health services such as sanitation, water supply, etc?

iv. What should be the mechanism monitoring the health care needs of the members of HCC? Invariably, in a joint family system the health care needs of female members and also the elder non-earning members do not receive adequate attention. What measures need to be taken to avoid such an eventuality in the HCC?

v. How should the internal medical knowledge resource particularly about traditional medicines and healing, be harnessed in the case of HCC?

vi. In order to reduce the cost of medical care particularly for the less privileged members of HCC, can the medical care expertise available within the catchment area of HCC be mobilized on an honorary basis? Are such socially motivated resources of medical expertise available in the villages of Karnataka? How to mobilize such resources?

vii. What level of health care services can be assured from HCC? In other words, should HCC restrict itself to the provision of primary care only? In case, secondary and tertiary care are needed, then, what special arrangements be incorporated as a part of HCC.

viii. Should HCC be linked to the Medical Insurance System obtaining in the state?

ix. Can HCC be an effective substitute for the present Primary Health Centre (PHC)?

x. What linkages can be visualized between the HCCs and PHCs?

xi. Which villages should be selected for the purpose of trying out the idea of HCC?

xii. Should HCC be tried in the urban areas also? The questions of desirability and feasibility of an urban HCC may be examined.

In our study we would like to consider the experiment of HCC in selected regions of Karnataka on a pilot basis and compare its efficacy with that of PHC in the present health care delivery system. The study essentially aims at providing a replicable methodology which is cost effective, pro-poor and needy and effective in using the spirit of cooperation and sympathy among the people for the purpose of supplying health care services.

We also include here another note which provides a list of issues for empirical investigation on the theme of economic reforms and the health sector.

Notes

Economic Reforms and the Health Sector: Analysis of the Nexus

In the present note an attempt is made to list down the major issues relating to the nexus of different economic reforms with the health sector, which deserve further empirical study. Some studies undertaken by CMDR and elsewhere have made certain observations relating to the effects of economic reforms on the health sector budget. However, a comprehensive study of all the major related issues would facilitate our understanding of the scope of economic reforms and their implications for access and utilization of health care services on the one hand and health care status on the other. Though for the purpose of analyzing the effects of the reforms for health care status the nine to ten year period of the reform process may not be adequate, this period seems to be fairly sufficient for analyzing the linkages between economic reforms on the one hand and access and utilization of health care services, on the other. The major issues for empirical investigation are listed in the following chart according to each of the major heads of economic reforms.

Empirical Study Plan: A Chart of Issues to be tested for analyzing the nexus between economic reforms and the health sector

I. Trade Sector

Reform Item	Issues for Empirical Testing
1. Import Tariff 2. Export Tariff 3. Withdrawal of CCS 4. Dilution of Licensing system	i. Has reduction in tariffs reduced the prices of drugs for the final consumer? ii. Has the tariff reduction reduced the costs and raised the effectiveness of medical education? iii. What are the indirect effects of these cost reductions on the parent's decision making to finance medical education and medical care services? iv. What is the import content of medical care, education and medical care services? Have the measures for diluting the licensing system v. Promoted the health care related economic activities? Have these measures led to financial inflows for the medical care sector more than for the 'public health' sector?

I. *Trade Sector (Contd.)*

Reform Item	Issues for Empirical Testing
1. Devaluation 2. Dual Exchange Rates 3. abolition	i. Have different doses of devaluation and abolition of dual exchange rate regime led to positive income effects for the exporters of health related goods and services through promotion of exports? ii. What is the extent of import content of health sector related export activities? iii. Has the devaluation and abolition of the dual exchange rate regime caused a rise in the import bill of the exporters of health sector related goods and services?

II. *Industrial Sector*

Reform Item	Issues for Empirical Testing
1. Drastic scaling back of industrial licensing system (except 18 core sectors) 2. Policies promoting capital mobility 3. Relaxation of MRTP Act. 4. Opening up of industries 5. to the private sector-privatization. 6. Liberalization of FDI and foreign portfolio investment 7. Relaxation of FERA 8. Foreign investment up to 51% of equity holdings permitted in 34 industries.	i. What are the direct and indirect effects of the reforms relating to the industrial sector on the pharmaceutical industry, the industry producing medical care equipment, refrigeration, oxygen plant, etc.? ii. Have the promotional policies relating to the industrial sector resulted in larger investment in the health and medical care related industrial activity? iii. Have these policies led to cost advantages and positive income effects for the entrepreneurs in these health sector related activities? iv. Have these measures finally led to larger resource availability for the health sector? v. Have the measures to relax FERA and permission for foreign investment up to 51% of equity capital led to larger investment flow from abroad into the health care sector? vi. What relative advantages are attained by the health sector as compared to other sectors as a result of NRI funds flow? vii. How many foreign collaborative initiatives have been signed in the health care sector during the period after the introduction of these industrial sector reforms? What are their effects on supplies of services? viii. Have the income effects arising out of the industrial sector reforms affected the availability of medical care services in rural areas in particular?

III. Financial Sector Reforms

Reform Item	Issues for Empirical Testing
1. CPR and SLR lowered, implying less governmental access to the resource of commercial banks. 2. Interest rates deregulated And brought down. 3. Post of Controller of Capital Issues was abolished but Security Exchange Board of India. 4. (SEBI) was established. 5. Increased level of foreign portfolios investments.	i. Have measures of financial sector reforms led to larger availability of funds for the private initiative in health care sector? ii. Have the liquidity advantages for the health care related activities of the private sector caused a corresponding disadvantage for the public sector initiated health care measures? iii. What is the effect of this on the availability of health care services for the less privileged sections of population and also for the people in the rural areas who normally depend upon the public sector supply of health care services? iv. Have the budgets of the PHCs got compressed during the reform period? v. What is the incidence of this budgetary compression at the micro level? In other wards, which components of the expenditures of PHC are affected as a result of the liquidity disadvantages for the public sector initiatives? vi. How far are the expenditures/investments in health care sector interest elastic? vii. Have the reductions in interest rates favourably affected the investments by the private sector borrowers for starting of new health care related ventures? viii. Have these ventures been initiated in rural areas as well? ix. Have the private medical practitioners found the interest reductions advantages on to start their clinics and consultancy centers with borrowed funds? x. How many such new initiatives are taken by the private medical practitioners, with the borrowed funds during the reforms? xi. Have public sector units in heath care sector (public hospitals, PHCs, government medical care and medical educational institutions etc.,) started borrowing from the banking system in the open financial markets for the purpose of meeting their budgetary needs?

IV. *Fiscal Policy Reforms*

Reform Item	Issues for Empirical Testing
1. Reduction of fiscal deficit 2. Economy in non-plan expenditures. 3. Tax rate reduction (all taxes) 4. Relative importance of direct taxes vs. indirect taxes raised (from 1:3 to 2:3) 5. Widening of tax base 6. Introduction of presumptive taxation. 7. Bank credit to the government reduced by 44 percent. 8. Central government debt held by RBI reduced from 15 percent to 10 percent. 9. Central government budget deficit financed by RBI reduced by 33 percent to less than 25 percent. 10. Net Central government debt held by RBI reduced by 15.6 percent of GDP to 9 percent of GDP. 11. Net external borrowing declined significantly (share declined). 12. Corporation and income tax together increased from 2 percent to 3 percent of the GDP. 13. Excise and customs duties' share reduced from 9 percent to 7 percent of GDP. 14. Non-interest expenditure reduced from 16 percent to 13 percent of GDP. 15. Reduction of subsidies	i. Are fiscal deficits and outlay on the health sector related? A study of this behaviour at the union government and the state government levels? ii. How have the measures of economy in non-plan expenditures affected the health care expenditures of the government? What effects are seen from these measures on maintenance and up keep of different components of the activities of the health care sector? How have these measures affected the quality of public health and medical care services? Has there been a differential effect on the health care services supplied in the urban areas and the rural areas, as a result of the measures of economy in non-plan expenditures? iii. What are the liquidity advantages for the private sector initiatives relating to the health care sector due to reduction in fiscal deficit and economy in non-plan expenditures at the union government and the state government levels? iv. Have the measures for reduction in rates of income tax caused positive income and substitution effects for the supply of health care services? v. How have the reduction in indirect taxes, excise duties and sales taxes (and other types of indirect taxes) affected the costs of supplies of health care services? vi. Have these cost advantages due to tax rate reduction been transferred to the final users of health care services? vii. What effects have been felt on account of the dilution of a fiscal illusion due to dominant direct tax share in the overall tax burden in the economy?

IV. Fiscal Policy Reforms (Contd.)

Reform Item	Issues for Empirical Testing
	viii. Has widening of the tax base, bringing the hither- to non-taxed persons under the tax net (say, through presumptive taxes) affected the disposable income of such new tax payers and there by affected their expenditure on health care services? In other wards a close study of the changes in household expenditures on health care services during the reform period and analysis of the factors responsible for these changes. ix. What are the effects of reduction in subsidies relating to the goods and services of the health care sector on the composition and size of the health care expenditures by the households? Similarly, what are the effects of subsidy reduction on the producers and suppliers of health care services, at the state and the sub-regional level? x. Have the proposals relating to the health care sector submitted by the state government been sharply cut in the plan discussions during the reform period? xi. What is the extent of the 'coefficient of distrust' in the course of decision making for the plan financing and also the financing of the non-plan expenditures relating to the health care sector? xii. Analysis of the proposals submitted by the state government to the planning commission and finance commission relating to the health care sector, subject to the availability of the official records xiii. Information about subsidiary points needs to be analyzed. How far have the fiscal policy reforms introduced at the union and the state government levels affected the process of decentralization relating to the health care sector? Effects on the expenditures of the districts, in selected states.

V. *Agriculture Related Reforms*

Reform Item	Issues for Empirical Testing
1. Abolition of GOI restriction on the movement of agricultural commodities between zones. 2. Freeing of prices on some fertilizers. 3. Quantitative restrictions on agricultural trade dismantled.	i. Have agricultural sectors specific reforms affected the ability of farm households to pay for the medical care services? Have these reforms worked in unison with the reforms relating the other sectors in promoting or discouraging the health care sector's activities?

VI. *Overall Effects of Economic Reforms*

Reform Item	Issues for Empirical Testing
	i. What are the effects of considering price as a major instrument of planning and resource mobilization so far as the health care sector is concerned since price is emerging as a major instrument? ii. What are the implications of such a system of funding on the composition of health care services? What are the effects of a mixed system of funding consisting of 'price', based upon the quid-pro-quo principle with regard to some components of health care services and another, based upon the general system of non-price linked financing (e.g. In the case of clean air, clean water, parks, sanitation facility life saved etc.)? Has the economic reform process affected the composition of the supply of health care services?

VI. *Overall Effects of Economic Reforms (Contd.)*

Reform Item	Issues for Empirical Testing
	iii. What are the effects of considering price as a major instrument of exclusion, on distribution and utilization of health care services? Have the socio-economically less privileged sections of population been feeling greater degree of deprivation in the course of economic reforms? iv. Have multi-nationals taken any initiative in improving the access and utilization of health care services in rural areas? v. Has there been a differential treatment of the rural areas of the developed and less developed states? Analysis of this issue with a mapping of health care services in the case of one of the states. vi. Classification of health status indicators which are likely to be affected by the economic reforms in the short run, medium run and long run. vii. The effects of economic reforms on different population groups such as the child population, elderly population, women, school boys, workers in the organized sector, workers in the un-organised sectors etc. viii. Analysis of the effects of reforms on these population groups in different states with varying levels and rates of development. Are the less developed states being treated less favourably by the economic reforms as compared to the developed states, so far as the effects on the access and utilization of health care services - public health services, medical care services etc., are concerned? What changes are felt during the economic reforms in the access and utilization of health care services by the specific population groups in the states of different level, and rates of development?

The empirical studies of the issues outlined above should be of great significance for policy making, for, the likely adverse implications of economic reforms may be countered by introducing the necessary corrective measures. Also the likely favourable effects of the reforms for the health care sector may be strengthened by suitable supplementary measures. A balance sheet of favourable and unfavourable effects of economic reforms on the health sector would provide insights about the credibility of the economic reforms themselves, so far as the social sector in general and health sector in particular is concerned.

It is proposed to compile the relevant literature examining the nexus between the economic reforms and the health sector in the context of other developed and developing countries as well. This background literature may help undertaking a detailed empirical study in the Indian context with a focus on the experiences of selected states according to the levels of development. Thus, the next phase of the study would consist of a detailed examination of the above issues in the case of Maharashtra a developed state, Karnataka a medium developed state, and Orissa or Madhya Pradesh a less developed state. Insights obtained from such an empirical study would help planning of a detailed micro-level study of the nexus of reforms with the health sector using the household level date in the selected states. As an exercise for micro level intervention, the proposed study would try out the idea of 'health care cooperatives' in the context of a selected region of Karnataka using the insights from the household level enquiries in the three selected states. In case the idea of health care cooperatives would work in the selected regions then it is proposed to suggest a replicative intervention strategy for other regions also for the purpose of maximizing the advantages and minimizing the disadvantages from economic reforms for the health sector. Since the action component of the study would also benefit some of the less privileged sections of the population of a region of Karnataka this part of the study in itself would have some positive aspects. ■

14 Protecting Consumers' Health in Developing Countries

Debabar Banerji

The terms, 'developing' and 'developed' countries will be used in a broad, generic sense. It is not necessary here to enter into a semantic debate concerning definitions. It is also recognized that there are considerable diversities among the countries put under these two groups. The emphasis here will be that, taken as groups, these are 'poles apart' in more sense than one. Their relationships are based on unequal terms.

For reasons that need not be gone into here, developed countries generated conditions which created the phenomenon of European Renaissance. Development of science, technology, industry and commerce gave them a head start over the developing countries. This enabled them to acquire strong political and economic control over the other group. This gap has been widening all through the centuries. Developing countries are made to lose their autonomy in decision making on issues that vitally concern them. They are left behind to follow the mirage of 'catching up' with the developed ones.

Western medicine has developed under such a setting. It registered spectacular breakthroughs, particularly during the past century and a quarter. From a scientific angle, it has reached dizzy heights, as

manifested, for example, by advances in diagnostics, special surgical procedures and a wide spectrum of therapeutic practices. Over and above, new areas such as genetic engineering, biotechnology and in vitro culture of tissues of organisms, which includes humans.

As observed by the great German medical thinker in the mid-nineteenth century, Rudolf Virchow, 'medicine is a social science'; it is greatly influenced by social forces. Three major social forces which have influenced medicine will be very briefly referred to in the following paragraphs.

The issue of access of medical and public health services to the people had come up since the time of Bismark, when he developed 'socialized medicine' in Germany. People in the present developed countries had to struggle hard to obtain universal access at least to fundamental health services/insurance. Today, in most of the developed countries the state accounts for above eighty per cent of the total cost of health/insurance services. Even in the US, it is over fifty per cent. In a startling contrast, in a massive developing country like India, the percentage is less than twenty-five. To further compound the situation, now, under the Structural Adjustment Programme (SAP) pressure is being exerted on the country to further 'downsize' state intervention in the field of health.

There has been considerable unease over the way Western medicine is being practiced even in the developed countries. Ivan Illich is among those who made a comprehensive, well-documented critique this vital area. He starts his famous book, MEDICAL NEMESIS, by asserting that 'medicine has become a threat to the health of the people'. He substantiates his arguments by drawing attention to various kinds of iatrogenic diseases - diseases caused by practitioners of medicine. Medicalisation of lives of people, mystification of medicine, professionalisation and centralization, dependence creation and actively promoting addiction to medicine, are some of the terms he has employed for making a devastating denunciation of practice of Western medicine.

So powerful have been the economic interests behind the 'sale' of Western medicine to the consumers that the overwhelming evidence adduced against these aspects of the practice were simply ignored or 'forgotten' and they have succeeded in generating an exponential growth of the highly faulted medical system all through the years. This has substantially added to the GDPs of the developed countries. Medicine has now become a commodity. Big corporate organisations have come into being to sell medical services to customers are 'suitably motivated' by subjecting them to relentless bombardment with well-designed media

onslaughts. For instance, an entirely new and booming 'fitness' industry has now come into being to sell 'fitness' to such intellectually sanitized people, who are conditioned to rush to buy designer made paraphernalia of various kinds.

After ensuring that markets are thrown open to 'free trade' by imposing the SAP on developing countries, the developed countries have expanded their markets by including the much vaunted burgeoning middle class in the developing countries in its brainwashing agenda. To the 'forgotten' people of the developing countries, those 'who live on the other side of the moon', these business ventures in medicine conform to what Illich had observed long ago - a menace to their health. Perhaps unwittingly, physicians have often become sales agents of this massive 'medical industrial complex'. That President Clinton could not push through even the very highly diluted health care programme for the people of the US, despite the most solemn promises made in his campaign to get the second term, attests to the awesome power of the business interests. Those who live on the other side of the moon in the US were bluntly told that there is 'no free lunch'. This conforms to the famous saying of the US president just before the Great Depression: 'The business of the US government is business'.

This was the structure and content of Western medicine which the developing countries encountered when it was inducted into these countries by some of the developed countries in the wake of colonial/imperialist conquest. This encounter has to be considered here both in terms of time and space, against the overall social, economic and political dynamics. When Western medicine was imposed on the different developing countries, the people there had their own, indigenously developed mechanisms for coping with their health problems. The motive force behind the induction of Western medicine in these countries was to provide protection to the ruling class.

In the countries which were colonized by the developed countries, it was made accessible to the military, the colonial administrators and the traders; it was also made accessible to the wafer-thin uppermost level of the native gentry, which collaborated with the exploiters. Thus, right from the initial phase, Western medicine was used to strengthen the exploiting classes. The increasing impoverishment of the exploited as a consequence of colonialists joining the local gentry to extract some extra revenue created conditions for increasing the already heavy load of diseases and deaths among them. At the same time, with the native elites developing a fascination for Western medicine, the quality of the indigenous practices that were developed to cope with their health problems over centuries suffered because of lack of nurturing of these practices. The vast

masses of the people, the 'forgotten' people, thus suffered additional disadvantages when Western medicine was introduced in these countries.

However, here too there was a dialectical response from the people. Conditions generated by the anti-colonial and anti-imperialist struggles impelled the 'leaders' of the movements to think of ways to meet the health services needs of the vast masses. Significantly, because of fundamentally different socio-cultural, economic, political, epidemiological and technological conditions, the response too had to be fundamentally different, thus laying the foundations of what is now being termed as New Public Health. It had been a long, grinding struggle for the masses. The idea of a 'Barefoot Doctor' took the final form in the post-revolutionary China, while the leaders were groping for alternatives. During the anti-colonial struggle in India evolved the idea of the Primary Health Centre to provide low cost, efficacious comprehensive health services to the unserved and the undeserved populations and that of 'entrusting people's health in people's hands' through Community Health Workers elected by the communities. Scholars from other countries also contributed to the growth and development of this new, people-oriented health services which are tuned to the specific conditions prevailing there; 'health by the people'.

Under the leadership of Halfdan Mahler, WHO not only encouraged this trend, but it actively acted as a catalyst to give the movement considerable momentum, which culminated in the World Health Assembly (WHA) adopting the famous resolution on Heath For All by adopting the approach of Primary Health Care by the year 2000 AD (HFA2000/PHC) and getting all countries of the world specifically endorse the new philosophy in the Conference on PHC at Alma-Ata in 1978.

The Alma-Ata Declaration marked a watershed in the history of public health practice in the world. Health was declared as a fundamental human right for all the people of the world. People, rather than technology and industry were considered to be prime movers; community self-reliance or community involvement in every phase of health service development was the keyword. Social control over the health services; intersectoral action in health; coverage of the entire population with integrated health services; use of technology that is appropriate for the people, including use of traditional systems of medicine; use of only a very limited number of essential drugs in generic names, were some of the highlights of the Declaration. Halfdan Mahler also took the initiative in getting the approval of the WHA to have a WHO Programme on Essential Drugs; the WHA also approved for enforcement a Code for marketing of baby foods in the poor countries of the world.

The response from the rich countries to the poor countries daring to declare self-reliance in health was swift and sharp, as it affected their economic and political interests. They 'invented' the very untenable concept of Selective Primary Health Care. They used their financial clout to mobilise international organisations like the World Bank, WHO and UNICEF to let loose a virtual barrage of 'international initiatives' on the poorer countries, which almost swept away the tentative steps that were taken by some of the poorer countries in implementing HFA 2000/PHC. These programmes are the very antithesis of the Ala-Ata Declaration: they are technocentric; they are imposed on the people from the distant top, often to serve their commercial interests; they made the countries dependent on resources from outside; and they are certainly not cost effective, often they are patently unsustainable. The Universal Programme of Immunization, the Global Programme on AIDS and the Global Programme on Tuberculosis are the outstanding instances of such initiatives. Not unexpectedly, each one of them has failed to fulfill the promises that were made at the time of their launching. In the 'bargain', assigning over-riding priorities to such programmes had a devastating effect on the primary health care services in the developing countries.

Meek acceptance of the Structural Adjustment Programmes dictated by the developed countries through international banks by leaders of many developing countries is a mere episode in the long chain of their domination of the former over the latter. The Uruguay Round of the global trade talks, the imposition of the grossly unfair Trade Related Intellectual Property Rights and the infamous Dunkel Draft, which led to the establishment of the exploitative World Trade Organisation, were parts of this chain. Some of the more despotic among the leaders of governments of developing countries were lured to take their countries into debt traps which virtually destroyed whatever health services they had and thus considerably accentuated the suffering of the 'forgotten' people.

As is evident from the foregoing, access to health services by consumers in the developing countries has been getting restricted well before the world acquired an unipolar power structure. SAP dwelt yet another blow to the battered system. Sharp slashing of the already meager budgets of the public sector health services, dismantling of the barriers to 'free' trade, including giving up even the pretense of controlling manufacture and trade in drugs, and encouragement of rapid expansion of the private sector, have been some of the hallmarks of the SAP as it affected the consumer's health.

With the increasing commodification of medical services, which, significantly,

coincided with a very rapid growth in the market for high technology in the practice of medicine in the developed countries, even the medical personnel employed in government medical services have developed a vested interest in the further degeneration of the of the already decaying public health institutions. This led to rapid proliferation of high technology equipped corporate hospitals to cater to the needs of fast growing, high consuming rich 'middle class' which emerged from the liberalization of the economy following implementation of SAP.

The salesmen from industrialized countries became so blatant in promoting the their products that they took recourse to the grossly unethical practice of 'manufacturing' health problems which they declared, without a shred of scientific evidence, to be of serious dimensions in order to create market for products brought out by their companies! There is a distinct linkage between the development of vaccines by the bio-technology industry in the West with the sudden massive media projection of the six immunizable diseases as the principal causes of infant mortality and the subsequent launching of the WHO/UNICEF's Universal Immunization Programme. Sometime back, a highly placed immunologist of India claimed, without an iota of data support, that 'hepatitis non-A ad non-B is a major health problem in the country'. It turned out later the reason for his 'manufacturing' the disease was to promote use of the vaccine which had been recently developed in the United States to combat that disease. Whither are the forgotten people who are dying in their millions of communicable diseases and diseases associated with poverty and hunger?

Worshiping of the market forces has led to abandonment of even a pretense of following certain ethical norms. It has deteriorated to such a level that in a volume 14 of the World Health Forum (1993, pp.105-139), WHO considered it worthwhile to initiate a global debate in the form of Round table entitled: Would Machiavelli now be a better guide for doctors than Hippocrates?

Over time, even the most determined supporters of free market in the developed countries have been forced to adopt very stringent mechanisms to regulate licensing and practice of medicine. In developing countries, however, the jungle law of the free market is given a free play. As in the sale of any other commodity, the professionals in the private sector are given enormous latitude to fleece the 'clients'. In the absence of properly enforced regulatory mechanisms, in many countries prices of many essential drugs have sky-rocketed, their little supervision of the quality of drugs, drugs that are banned in the developed countries are being sold freely in the market and there are innumerable brand names, a large number have little therapeutic value.

Two recent very carefully conducted national sample surveys (one by the National Sample Survey Organisation of the Government of India, Forty-second Round, 1992 and another by the prestigious National Council for Applied Economic Research, New Delhi 1992) on the pattern of utilization of medical services in rural and urban populations present a most disturbing account of the consequences of the neglect of the health services in the country. One of most deplorable finding is that both rural and urban people have almost completely lost their indigenously developed mechanisms of coping with their medical problems and as many as 90 per cent of them opt for Western medicine for coping with their ailments. The public health infrastructure even for providing medical services to the people has virtually disappeared and the helpless people are forced to depend on an exploitative private sector. It was found that for the same type and quality of services, the poor have to spend a substantially larger amounts of money than the rich and that among them expenditure on medical services is the second largest most frequent cause of indebtedness, next only to dowry. Similar, and often worse, predicaments are faced by people in many other developing countries. This sums up the problems for consumers' health in the developing countries.

Lately, apparently to push the many 'international initiatives' it has been made to promote, there have been many question marks on the validity and reliability of some of the data presented by WHO. However, even after giving them a wide latitude, the 1996 World Health Report presented by the WHO director-general paints a grim picture (WHO Forum vol. 18, pp1-8, 1997): more than 1000 million people live in extreme poverty; malaria still strikes up to 500 million people a year, killing at least two million; acute respiratory infections kill almost four million people every year; tuberculosis kills three million annually; Diarrhoeal disease still kill nearly three million people every year; HIV / AIDS has infected up to 24 million people, out of whom four million have already died.

An account of the hundreds of millions of premature deaths and easily preventable diseases faced by the 'consumers' of health of those who accounted for almost the entire populations of many of the developing countries is a part of the account of long running confrontation between the 'haves' and the 'have nots' on grossly unequal terms. Political leaderships of the developed countries provided the major striking force for the oppression of the have-nots; the haves among the natives actively collaborated with them in carrying out this oppression. Inevitably, despite their tremendous disadvantage, as they have little to lose, the 'haves' have mounted a sustained struggle against injustice and exploitation. The consumer movement for health in the developing countries will take the side of

the wronged people. Their demands are enshrined in the Alma-Ata Declaration - this includes struggle for a rational drug policy, access to people oriented health services and a more humane and broad based, empowering population policy. This part of the struggle for human rights of the have-nots. History ordains that this struggle will continue.

Poverty, Health Services and Development

An overwhelming proportion of the poor people of the world live in developing countries. About a third of them are abjectly poor, in the sense that they are unable to get even two square meals all round the year. Another third or more, though somehow manage to have the two square meals, nevertheless, live most degrading lives. These people have thatched huts, shanties or overcrowded dilapidated buildings for their living. Very few of them have sanitary latrines or easy access to protected water. The overall environmental sanitation is exceedingly poor, with virtually no arrangements for disposal of human, animal and kitchen waste, and drainage of wastewater. Various kinds of insects and pests thrive in the ecological conditions created by these deplorable levels of human existence. Earning of the meager resources for keeping alive entail hard, backbreaking work, often under hazardous conditions. Amelioration of these conditions need social and political action to usher in a more just social and economic order.

The very well-off section of the populations in these countries, constituting the upper 5 percent or less of the populations, have acquired the power to dominate the social, political and economic lives of the rest of the population. From time immemorial, the poor have undertaken struggle to wrest their rights from the dominant rich.

These also create conditions for high levels of incidence and prevalence of various kinds of acute and diseases which sap the lives of the people; the suffering caused by the diseases further disempower them, thus leading to the perpetuation of the unjust social and economic relations. It is in this context that provision of easy access to health services acquire a political significance: (a) it empowers people by substantially alleviating the huge load of the suffering caused by diseases; (b) an additional source of empowerment is the consciousness that is generated among the hitherto neglected people about their right to have services from public institutions; and, (c) perhaps more importantly, availability of access to health services can act as an entry point for the people to demand equity in such other fields as education, employment, land rights, access to protected water, housing, environmental sanitation, social and economic justice, and so on; health services have thus the potential of serving as a major lever for all-round development of the hitherto neglected and exploited segments of people of the developing countries.

The adoption of the Alma Ata Declaration by all the countries of the world in 1978 was a landmark in the oppressed people's struggle to wrest their rights from their oppressors. Subsequent events have shown that the oppressors have managed to thwart this important movement for self-reliance in health. ■

Section IV

Health Care and Ethics

15 Ethics of Care & Health Policy: International and National Women's Movements Mobilize for Change

Nalini Visvanathan

A broad synthesis of feminist approaches to the ethos of caring popularized by Carol Gilligan's Ethics of Care: Through critical exposition and evolution in the writings of feminist scholars, the Care Ethic is being situated in a broader political, social and economic philosophy. In what ways is the Care Ethic relevant to women and processes of international development such as Globalization? Ethics of Care challenges western liberal philosophy, questioning the primacy of a "rights" (justice) framework that is biased towards men. By challenging the gender-based power dynamics within traditional western ethics, the Ethics of Care approach has created common ground with women's health movements, nationally and internationally. The promotion of quinacrine sterilization (QS), without adequate testing for safety and efficacy, provides a case example for discussing feminist ethics and empowerment processes.

The Case of Quinacrine Sterilization[1]

Safer (Voiceover) Steve Mumford says he is trying to help Third World women, but he admits he fears that if the number of poor, uneducated people continues to grow, the United States will inherit the problem.

Dr. Mumford: If we don't control our borders, we will certainly become a Third World country. I mean, more than a billion people would like to emigrate here today.

Safer: With all the same problems of...

Dr. Mumford: Unemployment.

Safer: ...overpopulation, unemployment

Dr. Mumford: Hunger, housing, dirty-dirty water, the whole works.

Mrs. Karat: The kind of approach that these people have they have no qualms about using this method, which is reminiscent of Nazi methods. It is like chemical sterilization, which was used in the Nazi concentration camps.

Safer (voiceover) That may be overstating it, but quinacrine is being looked on with increasing suspicion. Beyond India, six other countries no longer use it

(CBS's 60 Minutes. October 18, 1998)[2]

Introduction

Quinacrine, a drug approved by the FDA and once widely prescribed as a prophylaxis for malaria, is now being promoted as a means for chemical sterilization of women worldwide through the efforts of two Americans, Dr. Elton Kessel and Stephen Mumford. In the 1970s, working out of his garage, Dr. Jaime Zipper, a Chilean gynecologist experimented with this method by inserting the liquefied drug into women's uteruses. In documented clinical trials of this preliminary method, the slurry was associated with the deaths of three women, two in the United States and one in Bangladesh. Although trials with the slurry ceased at this stage, Zipper continued to work on refining quinacrine for sterilization. He replaced the slurry with palletized quinacrine, which could be placed in the uterus by an IUD inserter. Once inside, the pellets dissolve forming a scar tissue that seals the fallopian tubes

1 Because of space limitations, the case description is not a comprehensive account of the controversial promotion of QS and the responses by women's groups and other health advocates and activists. The focus here is on the response to QS by women's health activists and the women's movements. The case description was enhanced by the insightful comments of Asha George and Betsy Hartmann.

2 Source: Transcript of *60 minutes*, October 18, 1998. CBS, New York.

and prevents conception. Because it takes 12 weeks for the tubal occlusion to be complete, a long-acting injectable contraceptive is recommended for administration simultaneously.

Zipper's discovery escaped scientific obscurity when it caught the attention of a large and well-known family planning organization in the United States. Funded by Family Health International, a non-governmental organization based in North Carolina and the recipient of US government funds for family planning research and promotion, Zipper started clinical trials of the method in Chile in the late 1970's. The FHI also undertook a small study in the US in 1983 and 1984 that benefited from the FDA's "investigational exemption for a new drug". However, concerns about safety prompted the organization to shut down the study and cancel the FDA permit it had been issued.[3]

Following the aborted FHI study, the World Health Organization (WHO) tested the drug in animal studies that showed possible mutagenicity. Quinacrine use could cause cells to mutate and posed the risk of ectopic pregnancy, a condition that could threaten the life of a pregnant woman. In 1991, the WHO issued an advisory warning against the use of the drug as a sterilant until its safety could be established through further animal studies. The FDA also recommended against human trials of quinacrine sterilization.

Promoters

Family planning promoters, who had hoped that quinacrine sterilization (QS) would soon be widely available, were disappointed. Longstanding family planning enthusiast Sarah Epstein voiced her unhappiness over the denial of this cheap method of sterilization to the thousands of women in the Third World who, she alleged, were desperate for it. She accused the WHO of denying these women a legitimate recourse to limiting their fertility and pointed out that half a million women died in childbirth every year, for which this method could be life saving.[4] Epstein, whose father Dr. Joseph Gamble founded the family planning organization Pathfinder, based in Boston, is a wealthy donor greatly invested in family planning programs.

Epstein found kindred spirits in two health professionals who shared her concern about population growth in the Third World and its economic and environmental

3 Betsy Hartmann & Nalini Visvanathan (1997) A risky business? Quinancrine used to sterilize women worldwide, has yet to be proved safe. *The Boston Sunday Globe*, August 3. Some case data is drawn from this article.

4 Epstein, a member of the board of Washington DC based Population Institute advocated for QS in the Popline, the Institute's newsletter as well as in other arenas.

implications for the United States. Dr. Elton Kessel, a former director of FHI and Dr. Stephen Mumford a public health specialist, who said that US national security was threatened by the influx of poor people from a different civilization.[5] After leaving FHI Dr. Kessel started a private organization, International Federation for Family Health, (IFFH), to continue his family planning work. Together with Mumford, who ran an organization, Center for Research on Population and Security, Dr. Kessel attracted the support of notable funders for varying periods. However, they have had steady support from Epstein and her husband Donald Collins, and the Leland Fikes and Scaife Foundations. It is noteworthy that all three groups donate to the Federation of Americans for Immigration Reform (FAIR), whose anti-immigration stance is propelled by neo-Malthusian fears of population growth, economic decline and environmental degradation.

Arguing that for less than a dollar, QS provides enormous benefits for poor women at an affordable price, Dr. Kessel and Mumford have mobilized sympathetic doctors in countries such as Vietnam, India, Pakistan, Indonesia and Bangladesh to use the pellets in their practice. The publication of findings from field trials with QS in Vietnam in the Lancet showed that governments and gynecologists were willing to test the drug on women without assurance of its safety.[6] Because of its ban in the US, the men relied on a Swiss pharmaceutical company Si Pharma to manufacture the quinacrine pellet to their specifications.[7] Once they take delivery, the men pack their suitcases and travel to Asia to personally deliver the drug to their collaborators and consult with them. Responding to his critics, Kessel argues that risk-benefit assessments, the cornerstone of clinical trials, favored the use of quinacrine sterilization in populations where maternal mortality rates are high and contraceptive prevalence is low.[8]

Women's Movements take up QS

The publication of the findings from the QS trials in Vietnam, in a prestigious medical journal, provoked strong reaction among health advocates and activists. Writing in Reproductive Health Matters, Amy Pollack and Charles Carignan of the Association for Voluntary Surgical Sterilization (AVSC) critically examined

5 BBC Horizon's video film *Human Laboratory* recorded Mumford's explicit statement.

6 Do Trong Hieu et al. '31, 781 cases of non-surgical female sterilisation with quinacrine in Vietnam,' *Lancet*, Vol. 342, pp 213-217 1993.

7 Si Pharma ceased production in 1998 in the wake of the negative publicity produced by media attention.

8 Kessel is a medical doctor and Mumford a doctor of public health. Articles in the Indian press often mistakenly referred to them as "two doctors" implying that both were medical practitioners.

the issues of safety and efficacy of quinacrine pellets for female sterilization.[9] A year after the Lancet publication AVSC convened experts' meeting to evaluate the quinacrine method of non-surgical sterilization. The report from this meeting urged caution in proceeding without adequate knowledge of the safety and efficacy of the drug and the completion of preliminary clinical research.[10] Marge Berer, editor of Reproductive Health Matters continued to report on the controversy, informing and updating her readers, many of whom were active in the international women's health movement.[11] She lists countries where QS is being used and the violation of ethical standards for clinical trials. At Dr. Bashir's clinic in Faisalabad, Pakistan, an independent nurse practitioner noted that patients were not informed that the method was not formally approved for use in the country and there is no procedure to follow-up patients. Sterilized women who do not return to the clinic are assumed to have no problems.

Early in 1997, members of the Indian women's movement filed a public interest lawsuit asking the Government to account for the growing use of an unauthorized drug by private practitioners in the country. The plaintiffs were the All India Democratic Women's Association (AIDWA), represented by its secretary Brinda Karat, Dr. Mohan Rao, chair of the department of Social Medicine and Community Health at Jawaharlal Nehru University and other faculty members. Although Saheli, an autonomous women's organization (AWO) was not named as a plaintiff, it supported the lawsuit and worked closely with the plaintiffs.

In March 1997, at the International Women's Health Movement meeting in Rio de Janeiro, the Committee on Women Population and the Environment (CWPE) organized a workshop on QS. More than 50 women's health activists, from 13 countries, gathered to share information for monitoring the two men and their collaborators, as well as for challenging the ideological basis of their enterprise. Discussing the impact of globalization on women's health, Indian feminist and economist Gita Sen called attention to the "market cowboys", Kessel and Mumford, who had brought QS to her home town Bangalore. In the months following the Rio meeting, CWPE began mailing packages of documentation on QS, including

9 Pollack, Amy E. and Charles S. Carignan, "The Use of Quinacrine Pellets for Non-Surgical Female Sterilisation," *Reproductive Health Matters*, No. 2, November 1993.

10 Carignan, Charles S., D.Rogow, and Amy E. Pollack,'The Quinacrine Method of Nonsurgical sterilization: Report of an Experts Meeting,' AVSC *Working Paper*, No. 6. July 1994.

11 Berer, Marge '*The Quinacrine Controversy One Year On*,' Reproductive Health Matters, No. 4, November 1994.

published research and notes on the activities of Mumford and Kessel. Later, it joined the Dutch organization Women's Global Network for Reproductive Rights, Montreal-based CERAS (Centred' Etudes et de ressources sur L'Asie du Sud), and Saheli to form the Quinacrine Alert Network and organized a protest at the 1997 meeting of the International Federation of Gynecologists and Obstetricians (FIGO). At this meeting, IFFH had sponsored a panel of gynecologists using QS in their practice, chaired by Sally Epstein. Women's groups in Copenhagen, notably Kulu for Women, lent their support to Dr. Mulay, the QAN's representative, who challenged the ethics of using a drug unapproved for human trials.

India

In India, health activists in the women's movement demonstrated outside the New Delhi offices of the Drug Controller of India and Dr. P.K. Jain, the current president of IFFH, who issued a press statement underscoring his patriotic duty to limit India's population growth. In Calcutta, Professor Malini Bhattacharya, former Member of Parliament mobilized a protest outside the clinic of Dr. Biral Mullick, who was featured in The Lancet, engaging in dramatic action to capture media attention. The offices of the CHIP Trust, to which Dr. P.Kini's practice was affiliated, became the target of protests by women in Bangalore. The Indian media responded to the movement's mobilization and published several reports and editorials on the abusive nature of chemical sterilization, drawing a comparison to Nazi experimentations.

The use of quinacrine had expanded in the last few years, particularly in India. In West Bengal alone, more than 10,000 QS have been performed. In Karnataka (where Bangalore is located), according to the Lancet, a project to sterilize 25,000 was underway a few years ago. Professor Shree Mullay of McGill University, who visited QS sites in Bangladesh and West Bengal reported that sterilized women were not being followed up and monitored for side effects.[12] She also observed that there were no procedures for informed consent. In July 1998, responding to a Supreme Court decree in favor of the plaintiffs in the public interest lawsuit the Government of India banned the drug.

Chile

In Chile, where Jaime Zipper developed the pellets, the drug was never legally approved. However, quinacrine sterilizations were commonly performed in Santiago's Hospital Sotero del Rio and

12 Shree Mullay, Quinacrine Sterilization: Unethical Trials, *Economic and Political Weekly*, April 26. 1997.

health centers in the city of Valdivia. In 1995, the Instituto de Saluda Publica (ISP) denied a petition asking for approval of this method. The Women's Health Journal reports that research has continued for over 20 years, during which 2000-5000 women have been sterilized in public family planning services.[13] Maternal Mortality is a serious concern for women's health activists in Latin America, where abortion is not sanctioned by law in many countries. Nevertheless, the potential dangers associated with QS are not acceptable to Dr. Maria Isabel Matamala, assistant coordinator to the Latin American and Caribbean Women's Health Network.

"...the routine use of a potentially mutagenic drug cannot be authorized, since the research which has been done has not proved the drug's safety. An argument based on relative need is contrary to everything we have gained.in regard to the concept and ethics of reproductive rights."[14]

Women's groups led by Foro Abierto de Salud y Derechos Sexuales y Reproductivos (Open Forum on Sexual and Reproductive Rights and Health); the Corporacion de Salud y Politicas Sociales (Corporation of Health and Social Policy, CORSAPS) and the Caribbean Women's Health Network have protested the use of quinacrine for many years. When ISP banned it on July 1 last year, it called for full withdrawal of the product from the market. Director Gonzalo Navarrete, who headed the Review Committee on New Products, which unanimously refused approval for the drug, noted the safety of the drug has not been been sufficiently proved. Meanwhile Jaime Zipper, like his associates, Mumford and Kessel, emphasized the cost-effectiveness of the drug, its ease of use and alleged safety. Hoping the government will reconsider its decision, he has made alliances with health professionals and members of Parliament.

The long history of quinacrine use in Chile, dating back to the 1970s, is linked to the pro-natalist policies of the Pinochet regime, which restricted female sterilization. Shallot links this policy to the regime's appeasement of the Catholic Church's concern about human rights violations rampant in the regime.[15] Because of restrictions on the use of female surgical sterilization, which largely affected poor women, there has been a large unmet need tapped by QS proponents.

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13 *Women's Health Journal*, Caribbean and Latin American Women's Network, July -August, 1998. (Also, personal communication from Deborah Meacham, Editor.)

14 Ibid.

15 Shallat, Lezak 'Business as Usual for Quinacrine Sterilization in Chile,' *Reproductive Health Matters*, No. 6, November 1995.

US citizens - Mumford, Kessel, and Epstein have promoted and diffused the quinacrine sterilization method across populous countries in the South[16]. Now it may surface in neighborhoods close to home. On June 18, 1998, Alix Freedman's front-page story on QS and its promoters published in the Wall Street Journal was widely read and discussed. Because the media had paid this issue scant attention earlier, the extensive coverage given this topic placed it on the agenda of diverse agencies. Morley Safer, covering the story for CBS's 60 Minutes last fall let viewers hear from Brinda Karat, acknowledging the critical role of the movement in securing the ban on the drug. In the U.S. he interviewed Dr. Mildred Hanson, former director of Minnesota Planned Parenthood, who was willing to use QS in her practice. He also reported that a Florida doctor was recently found to have included QS in his list of clinical services. Benjamin views QS as "a practical answer to one of the world's biggest problems - overpopulation," and stated his intentions to provide it free to his low-income patients, while charging $200 for those who could afford it.[17] Both the 60 Minutes broadcast and a report that followed in The Wall Street Journal stated that the FDA had issued a notice to the men to destroy their stock of quinacrine pellets and refrain from any further promotion or distribution of the drug. However, the FDA's jurisdiction is limited to the US; it cannot curtail their activities offshore.

The QS case raises troubling questions for discussion: What are the implications of promoting the use of an unauthorized drug among poor women who cannot afford health care? Are unregulated markets appropriate for disseminating products that endanger women's health and bodily integrity? To what state authorities are these two QS promoters accountable - their government or those of their collaborators? Who should be made accountable? What are the rights of the women who have been targeted for QS? What should be the role of the women's health movement in framing national health policies?

In the final section the paper will provide a background and discussion for the case, after first reviewing theoretical and ethical perspectives that shape women's health policy.

16 Epstein arrived early in China for the 1995 Fourth World Women's conference, in order promote QS in rural China.

17 Benjamin's comments were quoted in the *Miami Herald* edition of October 4, 1998. In their web page, Mumford and Kessel mention that Benjamin's practice includes patients from USA, the Caribbean and South America. (www.quinacrine.com/news-981.htm). Dr. Benjamin's intentions are set forth in his web page: www.drbenjamin,com/QS.htm

Development Theories and Ethical Perspectives

The purpose of this paper is to explore theoretical and philosophical approaches to understanding development processes that affect women's health, particularly globalization, by examining the influence of feminist ethics in shaping health policy. Globalization threatens women's health as in the recent case of chemical sterilization of women with quinacrine pellets in several third world countries, after a WHO advisory had warned against the procedure. Interpreting the recent case of quinacrine sterilization and the responses of the women's health movements, nationally and internationally, with insights from feminist Care theory, the paper will argue for an enlarged role for the greater involvement of the women's movement in setting the agenda for health policy change.

Introduction

The first section will describe the case of quinacrine sterilization (QS), the promotion and dissemination of a drug unapproved for female sterilization in Asian and Latin American countries. It will document the Utilitarian assumptions that propelled two public health promoters, who claim to act in the interests of women. Free market systems, and deregulation, enabled them to supply drugs to collaborating gynecologists in several countries in Asia, who agreed to use the drug regardless of its unapproved status. Because of import de-regulations, reports of quinacrine sterilization activities in the media did not result in official interventions. Largely through the mobilization of the Chilean and Indian women's movements and the international women's health movement, the governments of the two countries banned QS.

The second section will first briefly discuss the globalization phenomenon before reviewing the common origins of ethical/philosophical perspectives and women's development theories. Because the mobilization of movements are strategic forms of political action by women and women's groups all over the Third World, any discussion of women's health in the development process must elucidate their contributions. Next is an exposition of the philosophical assumptions that guide Utilitarian approaches to health care planning and economic liberalization, both falling under the overarching ethics of justice.

The third section will discuss the ethics of care as a response to the shortcomings of the ethics of justice. What does the Care theory offer? What are its strengths and shortcomings? What are the approaches to Care in theories of women, gender and development? How can an emphasis on Care contribute to enriching social change theory as well as engender policies that foster health.

Finally, in the fourth section, the paper will examine the QS case within the framework of a feminist ethics of care, drawing from the works of political and economic theorists. Weaving together theoretical principles from gender and development, social movements and feminist ethical perspectives, it will analyze the role of women's movements in mobilizing over issues of care and shaping the health policy outcomes.

Globalization

Within contemporary developments, globalization is a term that is widely used to describe the interconnectedness of market economies around the world, unobstructed by regulatory state barriers. Folbre defines it as "the rapid acceleration of market exchanges across national boundaries."[18] While economic arrangements are at the center of globalization, the process leads to greater interdependence among nations having unequal power relations, reflecting growing inequalities both within and among nations.[19] Of relevance to this paper is the unfavorable impact of globalization on the health and well-being of all societies, especially those that are economically depressed. Yach and Betttcher's definition is broadly descriptive:

"More specifically, globalization is defined as the process of increasing economic, political, and social interdependence and global integration that takes place as capital, traded goods, persons, concepts, images, ideas, and values diffuse across state boundaries. (p. 735)[20]

These two authors argue that the way to address the complex health impacts of globalization is by formulating policies for collective action, such as transnational cooperation. Their list of global transnational factors that increase health risks and disease span political, economic, social, communication, environment and travel arenas, including short-term and speculative long-term consequences.

In the second part of their essay on the "Globalization of Public Health" Yach and Bettcher call for education and research to promote global awareness, analysis and action.[21] Their major prescriptions to address the current and impending crises include the establishment of transnational disease monitoring and surveillance

18 Folbre, Nancy "Care and the Global Economy,"draft background paper for the 1999 Human Development Report. October 30, 1998.

19 Navarro, V. Comment: Whose Globalization? AJPH, vol. 88, no. 5th May, 1998.

20 Yach, D and Bettcher, D. The Globalization of Public Health I: Threats and Opportunities, vol. 88 no. 5, May 1998.

21 Yach, D. and Bettcher, D. The Globalization of Public Health II: The Convergence of self-interest and Altruism, vol. 88, no. 5, May 1998.

systems, the development of international legal instruments and the use of mass media for public health advocacy. Most of all they call on national states to balance self-interest with altruism – a virtue that has little value in market-driven economic systems. Can nation states demonstrate altruism – a concept that underscores self-abnegation and is traditionally associated with women's caring role in the household? Their optimism surely stems from disregarding the significant power inequalities that characterize globalization for Navarro.

Structural adjustment policies that opened economies to market forces also initiated reforms in national health sectors leading to the downsizing or elimination of state provisions for health care, health and safety regulations, reproductive services such as child care and labor rights to occupational safety and health. Women concentrated in lower level positions as well as those heading households with children have been deeply affected. As Yach and Bettcher argue responses to address their needs must come through collective action and transnational cooperation, steered by agencies holding the mandate for global change. International movements that transcend conventional paradigms that perpetuate artificial divisions between nations and among countries must be recognized as an increasingly effective force in addressing health matters.

In his analysis of pressure groups (organized groups of people who seek to influence political positions), Willets defines transnationals as "groups that have contact with more than one country without involving governments."[22] Starting in the 1980s the communication revolution exponentially increased the volume and frequency of communications among non-governmental groups. He argues the multiplicity of pressure groups today, including women's groups that mobilize around issues of status and group identity, calls for more complex models of global politics. For example, while movements do not command authority, they can establish legitimacy for a cause. Ashworth, in her evaluation of the United Nation's Women's Decade, describes the contemporary women's movement as the most global "social movement."[23] The Quinacrine Sterilization case exemplifies the role of the women's movement as transnational actors in global politics.

Are transnational actors equal to local social actors. Tarrow draws a theoretical distinction between issue-based transnational networks and transnational

22 Willets, P. *Pressure Groups in the Global System*, France Pinter, London, 1982.

23 Ibid. pp. 125.

social movements. Using the story of a tuna war in the Bay of Biscay that pitted Spanish fishermen against their British and French counterparts, Tarrow identifies characteristics marking traditional social movements: the sequestration of social actors to force responses to key demands (QS protestors demonstrated outside the clinics and surrounded clinics and offices); the involvement of networks of social actors, previously organized within interest areas and defined regions (AIDWA chapters in West Bengal and Delhi joined with their networks); and turning to authorities (Supreme Court) for adjudicating the respective claims of the social actors (public interest law suit filed by AIDWA and others).[24]

Women and Development Processes

For more than fifty years women's roles in development processes have been analyzed and elucidated through the lens of theoretical models that have their roots in the works of western ethical and political philosophers such as Kant and Mills, Marx and Bentham. Both Liberal theory, which has branched into neo-classical economic theory and capitalist models of development, and Marxism, the intellectual source of socialist forms of governance and development, were the products of western philosophical challenges to a feudal order. Western feminists challenged the application of these models to the development process, when it became apparent that Third World women were being marginalized in this process of so-called development. A brief introduction to the history of development will help clarify the common links between ethical philosophies and development theories that are being reviewed here.

Background

In the years following World War II, the ambitious western project of international development got under way.[25] Its primary purpose was to increase economic growth in the nations of the Third World-a term coined contemporaneously with the polarization that created a capitalist (West) and socialist (East) power blocs. From the start, ideological differences have divided economic development scholars, planners and policy-makers, who were guided by economic theories falling either within the capitalist paradigm or the radical political economy framework.[26] The two paradigms, however, do not constitute a simple dichotomy either in theory or in the economies found in the

24 Tarrow, Sidney Fishnets, Internets and Catnets: Globalization and Transnational Collective Action", working Paper, Instituto Juan March de Estudios e Investigaciones, 1997.p. 5.

25 This section draws from the author's introduction in Visvanathan, N., L. Duggan, L.Nisonoff & N. Wiegersma (eds.) *The Women, Gender and Development Reader*, Zed Books, London, 1997.

26 Weaver, James H. et al. 'Competing Paradigms of Development,' *Social Education*, April/May 1989.

Third World. The capitalist paradigm has three notable variations: The free-market model, which advocates a reduced role for government in favor of private capital and market forces: the Malthusian approach, which addresses real or anticipated population growth through controlling population growth; and an interventionist model, which favors governmental intervention through regulatory and technocratic mechanism to redistribute income. A widely prevalent body of theory that is closely related to the neoclassical economic approach is modernization theory. This world-view steered the development establishment in the 1950s and 1960s and was influenced by the works of sociologists, political scientists and psychologists (Inkeles, 1974;[27] Lerner, 1958[28]; McClelland, 1961[29].) All these theories within the capitalist paradigm use individuals as the unit of analysis (versus communities or households); they also assume that individuals are economically "rational" and aim to increase their individual consumption without regard for equitable distribution of income.

Utilitarian philosophy shares some key assumptions with this paradigmatic approach; it promotes rational thinking and scientific approaches, striving to arrive at universal truths. As a consequentialist philosophy grounded in moral realism, it is primarily concerned with the outcomes of decisions or actions. It is concerned with equity and assigns equal weight to all individuals; however, unlike liberal philosophy also associated with the capitalist paradigm, it does not elevate individual rights. Subjective utilitarianism deals with individual preferences, emphasizing the monetary value of cost-benefit ratios. Objective Utilitarianism is concerned with the development of appropriate measures for a calculus to determine how the greatest good can be distributed to the greatest number and favors cost-effectiveness analysis. It is the approach adopted by reformers of the health sector and dominates health care planning and delivery in the industrialized democracies of the west.

The political economy paradigm, in contrast to the capitalist model, assumes that people are social beings who act together rather than in isolation. It embraces two main intellectual streams: dependency analysis and Marxism. (Dependency is an analytical frame rather than a theory with predictive capabilities).

27 Inkeles, A. *Becoming Modern: Individual Change in Six Developing Countries*, Harvard University Press, Cambridge, 1974.

28 Lerner, D. *The Passing of Traditional Society: Modernizing the Middle East*. Free Press, Glencoe, 1958.

29 McClelland, D. *The Achieving Society*, Van Nostrand, Princeton, N.J. 1961.

Dependency analysts believe that economic growth and industrialization of the western world came at the expense of those nations that were subjugated and exploited by colonial rule. The First World is seen as the "core" and the Third World as the "periphery" through which the center has been continually sustained. Consequently, these analysts argue that the periphery will develop only when it breaks away from the center. An important variant of dependency is the capitalist political economic world system. Elling provides a detailed exposition of capitalist multinational hegemony and its negative impact on world health.[30]

Starting with Ester Boserup in 1971, feminist economists critiqued the inadequacy of modernization theory and socialist theories in addressing the needs of women, who confronted patriarchal oppression in the workplace, the home and in the public arena. However, these critical assaults on the dominant paradigms were not directed at the main edifice but at the male biases found in their interpretation and application to development programs. Liberal feminists demanded that programs target women and bring them into the workplace, while Marxist feminists called for equal treatment of women workers, whom they saw as an integral part of the existing development process.

Theoretical Perspectives

In studies of women and the development process, three clear theoretical divisions emerged: (1) a Women in Development (WID) perspective that calls for the incorporation of women into the development process without challenging the modernization and capitalist paradigm; (2) a Women and Development (WAD) framework that argues that since women were an integral part of the development process the issue was their relationship to it and; (3) a socialist approach, "Gender and Development," which adopts a more holistic outlook and focuses on women both in the household and in the workforce.[31] More progressive in their stance, socialist feminists reject what they see as the false dichotomy between the public and the private lives of women and emphasize, instead, the social construction of gender roles. Questioning the assignment of rigid roles to men and women, they recognize the contributions of women's household work to the economy and, in particular, their functions as caretakers and caregivers of the family. By illuminating the private sphere and relations within the family through gender-based analysis, these feminists are asking

30 Elling, R. The Political Economy of International Health, *Research in Social Problems and Public Policy*, Vol. 2. No. 2, PP 97-147, 1982.

31 Rathgeber, Eva M. "Wid, WAD and GAD: Trends in Research and Practice,' *Journal of Developing Areas*, Vol. XXIV, July.

the state to extend its reach as much for shielding women against domestic violence as for meeting their welfare needs.

More than a decade ago, Nancy Folbre questioned the rosy depiction of unity and equality within the family by neo-classical economists, notably Nobel laureate Gary Becker (1986). Not finding the altruism that supposedly exemplified patriarchal conduct within the family, feminists have analyzed power relations within the household and the allocation of unremunerated labor to females in diverse settings across the world.[32] Because they hold the state accountable for women's welfare in the private sphere, socialist women have traditionally mobilized for bringing critical issues to the fore of public policy agenda. They view women's movements as a way to organize and challenge any and all forms of justice experienced by women, as well as a important instrument for policy changes.

Caroline Moser, a sociologist at the World Bank, has reviewed the history of different WID (liberal) policy approaches to Third World women, tracing their emergence and evolution.[33] Her survey found five approaches-welfare, equity, anti-poverty, efficiency and empowerment-some of them running concurrently. She assessed each approach for its ability to meet women's practical needs (PGN) that required immediate attention (employment, health and contraception services) and women's more strategic needs (SGN), which must be met to change their status in society (legal rights, gender-based division of labor, and domestic violence). The last two approaches are relevant to this paper. The "efficiency" approach is associated with the IMF's structural adjustment programs (SAPs) of the 1980s and stresses women's response to conditions created by the debt crisis in their local and national economies.

Moser depicts the empowerment approach as Third World feminist writing and grassroots organizing, which enable women to transform laws and structures that oppress them through a bottom-up process of organizing around practical needs. Although she does not refer to social movements, Moser describes the empowerment approach in terms of grassroots organizing.

The origins of the empowerment approach are derived less from the research of First World women, and more from the emergent feminist writings and grassroots organizational experience of Third World women; it accedes that feminism is not

32 Duggan, Lynn in Visvanathan, N., Duggan, L. Nisonoff, L. and Wiegersma, N. (Eds.) *The Women Gender and Development Reader*, Zed Books, London. 1997. Pp 104-106.

33 Moser, Caroline O.N. *Gender Planning and Development*, Routledge, London, 1993.

simply a recent Western urban middle-class import. ...the women's movement was not imposed on women by the United Nations or Western feminists, but has an independent history. (p. 74).

Moser's exemplary group DAWN, however, is not representative of the broad-based women's movements that organize across class, color, caste and ethnic lines. In India urban women's movements protested consumer price increases, coercive contraceptive practices, and bride burning; in Latin American authoritarian regimes, mothers protested the disappearance of their sons (Madres de plaza);[34] and Sudanese women organized against restrictions on their traditional practices[35]. Saskia Wieringa documents the 19th century roots of women's participation in social movements and their organizing for redress of grievances.[36]

Social Movements & Public Policy

To understand the nature of the connection between social movements, empowerment and policy change, we must create a political economic framework for elucidating the true relations. Movements are a form of political action often directed at changing public policies.[37] They comprise an amorphous body of individuals, groups and structured as well as loosely knit organizations that are bound together by a common purpose. Membership, or dues paying, organizations such as trade unions are the mainstay of movements because they are easily mobilized and prepared for organized action. Rochon and Mazmanian note that social movements are most successful in gaining entry into the policy process, because this is an area where authorities are more willing to be accommodating. When movement leadership is brought into the process, it could be through consultations, mechanisms for hearing grievances or the decentralization of the policy process. Even where they do not have an impact on policy change, movements may still have an impact on policy process. While they do not find much evidence of success in policy change, the authors concede that "the sense of empowerment is one important explanation for the involvement of so many people in contemporary social movements." They conclude that because of a time lag between policy response and movement activity, their findings on policy change may be an underestimate.

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34 Jaquette, J. *The Women's Movement in Latin America*, Westview, Boulder, and CO. 1994.

35 Gruenbaum, Ellen "The movement against clitoridectomy and infibulation in Sudan: public health policy and women's movement" *Medical Anthropology Newsletter*, v. 13, no. 2, p 4-12. 1982.

36 Wieringa, S. *Subversive Women*, ZED Books, London, 1995.

37 Rochon, Thomas R. and Daniel A. Mazmanian, 'Social Movements and Policy Process, Annals, *AAPSS*, July 1993.

Gamson[38] records two kinds of success: (1) Gaining new advantages for the protesting groups; and (2) Acceptance of protesting group as a valid representative for social interests that are newly legitimized (e.g. US Gay men's groups in the AIDS epidemic). Rochon and Mazmanian add a third category for movement success, "changing social values," suggesting that society and not government is the target of movement protest.

"By changing social values, movements expand the range of ideas about what is possible. This ultimately has an effect on politics because it changes perceptions of what the most important political problems are. In so doing, movements redefine the political agenda" (p.77).

When the outcomes were not successful, Gamson found the challenging groups preempted or co-opted. Thus, the influence of social movements can be evaluated in terms of changes in policy, process or social values.

Are social movements recognized in models of policy-making? Surveying policy environments in developing countries, Grindle locates popular action to penetrate state policy formation through two channels: clientelism (or pressure tactics) and public protests, more akin to riots[39]. Grindle's listing of policy elites include "societal interests" which embrace traditional interest groups as well as more nebulous groups. She finds organized interest activity less apparent in developing countries, overlooking popular movements in Asia and Latin America that often coalesce around issues of land and livelihood, political persecution and civil liberties. In their anthology, Escobar and Alvarez stress political strategies used for sociocultural, economic and political change.[40] ++++A well-known example of organizing to deal with SAP crisis would be the soup kitchens in the shantytowns of Lima, Peru. Feminists question the usefulness of interest-motivated politics in understanding the actions of alternative groups.[41] They claim that within the women's movement, "ideas about what should be pursued emerge through the process of political activism itself, rather than being clearly and fully articulated from the outset." (p. 9) Reich argues that health reform, or policy change, is a political process that requires full exposition of all players and positions.[42]

38 Gamson, William, The Strategy of Social Protest, Wadsworth, Belmont, CA. 2nd ed. 1990, ch. 3.

39 Grindle, M. and J. Thomas, *Public Choices and Policy Change: The Political Economy of Reform in Developing Countries*. The Johns Hopkins University Press, Baltimore, MD. 1991.

40 Escobar, A. and Alvarez, (eds.) S.E. *The Making of Social Movements in Latin America: Identity, Strategy and Democracy*, Westview, Boulder, CO, 1992.

41 Cohen, C.L., K. Jones and J.C. Tronto, (eds) *Women Transforming Politics: An Alternative Reader*. New York University, New York.

42 Reich, M.R. "Applied Political Analysis for Health Policy Reform, *Current Issues in Public Health*, Vol. 2,p p 186-191, 1996.

Ethics of Care: An Exposition

In her 1982 publication, In a Different Voice, Harvard psychologist Carol Gilligan's articulated an ethic of care that has generated a large following among scholars in different disciplines as well as an ongoing controversy – most heated within the feminist community – about its implication of gender-based differences in moral reasoning.[43] It is remarkable that this most influential feminist challenge to a male-centered western philosophy that marked the Enlightenment and the transition to a new political order, 200 years ago, came from a psychologist not a philosopher or political scientist. Partly because it was a reactive and remedial proposition, Gilligan's exposition of Care lacked the coherence and structure that critics were seeking. However, it undoubtedly challenged the androcentric foundations of the same liberal philosophy that shaped the dominant western paradigms of international development.

What is the Ethic of Care theory? What are its strengths and shortcomings? How does it differ from the ethics of justice, in particular Utilitarian and Liberal Egalitarian philosophical perspectives that influence northern-led international development? How can it contribute to enriching social change theory-our understanding of progressive catalytic processes in international development. Gilligan discovered that women she interviewed displayed a form of moral reasoning that she characterized as a distinct voice in ethical deliberations. Earlier developmental psychologists such as Piaget and Kohlberg, an associate of Gilligan, had traditionally excluded women from their research. When Kohlberg did include women in his research on moral development he found they were inferior to men, according to the criteria he had established.

It should be noted that developmental psychologists followed the tradition of liberal philosophy, in defining morality in terms of the ethics of justice, popularized by Kant and Rawls. Consequently, they measured moral development in terms of the individual's use of rights and universal rules or principles in forming judgements about hypothetical scenarios. From her interviews with young women, Gilligan discerned a distinctly different approach to moral reasoning that emerged from the centrality of relationships in the lives of women. Using these critical concepts as building blocks, Gilligan proposed an ethic of care that directly challenged the ethic of justice. She argued that the ethic of justice was focused on equality of rights

43 Gilligan, Carol, *In a Different Voice: Psychological Theory and Women's Development*, Harvard University Press, Cambridge, Mass. 1982.

and abstract universal moral principles that were seemingly impartial, detached and impassioned. The ethic of care, on the other hand, emphasized relationships rather than individual rights and context-specific moral judgments over abstract universal principles.

Although Gilligan's characterization of the two ethics suggests a gender correlation, she denies a rigid demarcation. In studies done in the late 1980s, she demonstrated that the ethical positions that men and women take are mutable and not confined to either Justice or Care. Tronto points out three major dimensions that distinguish Gilligan's ethic of care from the ethic of justice.

"First, the ethic of care revolves around different moral concepts than Kohlberg's ethic of justice, that is, responsibility and relationships rather than rights and rules. Second, this morality is tied to concrete circumstances rather than being formal and abstract. Third, this morality is best expressed not as a set of principles but as an activity, the "activity of care". In Gilligan's different voice, morality is not grounded in universal, abstract principles but in the daily experiences and moral problems of real people in their everyday lives." (Tronto, 1987, p.648).[44]

By bringing attention to the context of moral decision-making in daily life for diverse people, Gilligan enlarged the stage for moral actors. Now women and minority groups, the marginalized and the powerless could claim a voice in ethical debates. However, there were biases in her research that raised questions about its generalizability. As her critics point out, Gilligan's subjects were relatively homogenous and privileged - young, white and middle class women. Ironically, in this aspect, her work was vulnerable to the same charges she had levelled against Kohlberg.

Care and Liberal Egalitarianism

If we consider that the care ethic was a thesis expounded in opposition to liberal egalitarian assumptions, it is useful to juxtapose the two approaches. Care is concerned for the good of others in the community, and relies on an emotional connection for reasoning or deliberating over issues. Rights alone, cannot reduce the misery found in civil society or address the disadvantages inherent in unequal relationships (male/female being just one example). In a liberal egalitarian or Rawlsian approach, needs would be measured objectively to determine who has claim on another's resources and to what extent. In a care ethic, those who

44 Tronto, Joan C. "Beyond Gender Difference to a Theory of Care", Signs; 1987, vol. 12, no. 4.

intervene would have to imagine the suffering or predicament of others and think of an appropriate moral response. Analogous to the postmodern absorption with language or words for creating momentary realities, the care ethic finds empathy or identification with the situation or suffering of another to be superior to abstract moral reasoning typical of the liberal/justice mode of response. A corollary to this view is Care's respect for common distinct individuality versus common humanity.

Because their goal is accommodation, Care theorist's value process and resolve conflicts through contextual and inductive thinking which require taking the role of the particular other. The liberal/justice approach is concerned with upholding institutional rules and principles, limiting its concern to the generalized "other". (Utilitarianism is an exception in this respect as it does deal with particularity). In contrast to the liberal/justice emphasis on asserting or claiming rights, Care theory priority is responsibility. In stressing Care-an emotion-as the key concept framing this ethic, Gilligan and others have challenged the dominance of reason, the cornerstone of liberal philosophy and the justice ethic.

Care and Utilitarians

How does Care stand in relation to the Utilitarian approach, another form of justice ethic? Reconceptualizing moral philosophy through feminist lens, Virginia Held points out that the Utilitarians give the greatest priority to reason and offer "rules of rational choice for maximizing the satisfaction of individual desires and interests". As a consequentialist philosophy, Utilitarianism is not focused on individual rights; instead, rational choices are predicated, according to Bentham's injunction, on "the greatest good to the greatest number". However, Held finds it no different from liberal egalitarianism (deontological) in emphasizing abstract principles over emotional bonds:

"Like the Kantian approach, the Utilitarian approach relies on abstract general principles or rules to be applied to particular cases. And it holds that although emotion is, in fact, the source of our desires for certain objectives, the task of morality should be to instruct us on how to pursue those objectives most rationally. Emotional attitudes toward moral issues themselves interfere with rationality and should be disregarded". [45]

45 Held, V. Feminist Reconceptualizations in Ethics, in Kourany, J.A. (ed) *Philosophy in a Feminist Voice*, Princeton University Press, Princeton, 1998. P.98.

Currently, the field of public health is driven by objective utilitarian practices, which emphasize cost-effectiveness and efficiency. Unlike liberal egalitarian principles, which support redistribution of resources for greater individual good, the aim of objective utilitarianism is to produce welfare (good) with the least cost by treating individuals as the means to an end.

The Utilitarian emphasis on the role of experts making rational choices that are objective, scientifically measurable and efficient severely contrasts with Care's approach of imaginative identification with the other, leading to creative and transformative understanding that are appropriately responsive. Although the latter is ultimately consequential in terms of alleviating the suffering of the "other", it cannot satisfy the consequentialist's demand for a measurable outcome. The subjectivity of the Care practitioner and her acknowledgement of interdependence of the self and others nurture her connectedness with others, which foments collaboration and cooperation. Although practitioners of both ethics may have the same objectives, the one approaches through efficiency, the other through compassion.[46]

Internal Debates: Feminine vs. Feminist Ethics of Care

Is Care a feminist ethic or is it a separate sphere, feminine ethic that reinforces traditional stereotypes of women as domestic workers. Although this paper does not have the scope to cover the nuanced arguments that are put forth by the two groups, it is essential to underscore the controversial nature of Gilligan's treatise. Gilligan has denied her intention to present the care ethic as gender correlated and used later work to demonstrate that there can be a crossover between justice and care for both men and women. Two of the leading proponents of a feminine ethic of care are Nel Noddings and Virginia Held who have used mothering practices to elaborate the scope of the concept and explicate its ramifications. Groenhaut (p.171) finds the focus appropriate because mothering is "theoretically primary in developing an account of care and because it has largely been excluded from moral considerations."[47] She finds it similar to virtue ethics in its focus on human practices/ actions, but dissimilar in its lack of a specific conception of human nature.

46 The comparative analysis is based on lecture notes in Dr. Michael Reich's "Ethics" course at the Harvard School of Public Health. The comparison of Ethics of Care with Utilitarian theory is based on Dr. Fiona Percy's presentation at a department seminar.

47 Groenhout, R. "Care Theory and the Ideal of Neutrality in Public Moral Discourse, Journal of Medicine and Philosophy, Vol. 23, no. 2.

How is the feminist approach to ethics different from feminine approaches with which care is linked? Although a comprehensive account of the wide-ranging interpretations and critiques of Care is not possible here, this section will highlight some broad features. Bioethicist Rosemarie Tong points out that the use of the plural noun in "feminist ethics" is reflective of the diversity of views that prevail among feminists.[48] It appears that feminist ethics are distinctive for their deliberate assumption of a political perspective in analyzing issues. She quotes philosopher Betty Sichel on a distinction that is commonly made.

'Feminine' at present refers to the search for women's unique voice and, most often, the advocacy of an ethics of care that includes nurturance, care, compassion, and networks of communication. 'Feminist' refers to those theorists, whether liberal or radical or other orientation, who argue against patriarchal domination, for equal rights, a just and fair distribution of scarce resources, etc. (Sichel in Tong, 1997. p 37).

Tong, however, finds that these distinctions lead to misunderstandings and expresses her preference for a more inclusive definition of feminist ethics.

"Whereas a care-focused feminist approach to ethics has as its primary task the rehabilitation of such culturally associated feminine values as compassion, empathy, sympathy, nurturance, and kindness, a power-focused feminist approach to ethics has as its first duty the elimination or modification of any system, structure, or set of norms that contributes to women's oppression. (Ibid. p.38).

Under care-focused ethics, Tong includes Annette Baier, who thinks "trust" not "care" should be the central concept for a feminist ethic, on the grounds that the powerless need a voice. Because traditional moral theories prescribe ethical rules from the standpoint of those vested with power, she addresses the need of powerless people to trust those above them.

"To trust," says, Baier, "is to make oneself or let oneself be more vulnerable than one might have been to harm from others – to give them an opportunity to harm one, in the confidence that they will not take it, because they have no good reason to." (Tong P. 42).

Tong groups Baier with Gilligan and Nel Noddings as exponents of care-focused feminist ethics and finds a close association between their work and that of Virginia Held, Sara Ruddick and Caroline Whitbeck. Held, who has developed a penetrating analysis of difference between contractual and non-contractual relationships, argues for the moral superiority of the mother-child relationship. Although

48 Tong, Rosemarie *Feminist Approaches to Bioethics*, Westview Press, Boulder, and Co. 1997.

Tong positions her with ethicists who are absorbed with the interpersonal aspects of care theory, Baier's approach to care has a strong social component that distinguishes her from the others in this group.

Tong finds feminists who approach ethics through power-focused lens are primarily concerned about male domination and female subordination. For example, Alison Jagger stipulates that an ethic can be considered "feminist" only if it critiques "the gender biased character of most non-feminist approaches to ethics". In order to elevate women's moral experience with that of men, Jagger urges feminist ethicists to envision morally desirable alternatives that will promote women's emancipation. Regardless of the focus, a common objective that binds all types of feminist ethics is the need to address women's disempowerment as a result of a pervasive cultural bias against their gender-a mission that binds them to women's movements and organizing discussed earlier under Gender and Development and Moser's approach.

Care and Caring

Political theorist Tronto has expressed concern about the interpretation of Care in terms of gender difference has constructively addressed the deficits in this theory. She argues in a 1987 essay in Signs that the debate over Care should not center on its correlation with gender difference, but instead on its adequacy as a moral theory. (Tronto, 1987). Opposing the development of a women's moral theory that is merely a "corrective" to the prevailing male morality, she points out that an alternative theory would be treated as supplemental rather than central to ethical theory. Similarly, she discards the contextual approach to care, because of its bias toward relativism and its inadequacy in addressing all needs. In a later essay, reflecting theoretical development, Tronto suggested that feminists should analyze care within a political framework in order to view the "transformative and feminist aspects of caring". (Tronto, 1989; p. 102)[49] In her definition of the amorphous term "care", Tronto explicates two types of caring: "Caring about" and "caring for", distinguished by the objects of caring.

Unlike Nodding's restrictive definition of caring, Tronto envisions caring within social and political life and calls for a commitment broad enough to respond to the needs of strangers in distant shores. The significant question for her is how the duties of caring for others is given moral significance in society as a whole (Tronto,

49 Tronto, J. (1989) Women and Caring: What can Feminists learn about Morality from Caring? In Alison M. Jaggar and Susan R. Bordo, eds. *Gender/Body/Knowledge*, Rutgers University Press. (Page numbers from reprint in Held, V. (ed) *Justice and Care*, Westview Press, 1995).

1989; p.105). An analysis of Care relationships in society would reveal power structures and privileges in society.

Tronto distinguishes between the Ethic of Care and the practice of caring. The former is an ethical system that requires: "a commitment to attentiveness to the needs of caring, a willingness to assume responsibility for others, a commitment to the consequences of actions, a commitment to responsiveness." (Tronto, 1991. p.8).[50]

In Moral Boundaries (1993), Tronto expands her earlier two-pronged definition of Care to include four phases in the practice of care: Caring about (recognition that Care is necessary); taking care of (assuming responsibility and responding); care-giving (directly meeting care needs); and care-receiving (responding to care received).[51]

Tronto stresses that the work of Care is fragmented, given different weights and markedly gendered, raced and classed. Poor women of color dominate the lowest strata, taking over the menial jobs, while managerial jobs are disproportionately held by white men. Viewed as a private activity, Care conceals women's burden, "supporting the perception that Care is not a social concern, but a problem of idiosyncratic individuals".

Tronto's articulation of some of the problematic aspects of Care include parochialism - its potentially narrow "engagement with the concrete, the local, the particular"(142); The sublimated needs and the rage of caregivers - the friction arising between caregivers and receivers, and; Detached care and otherness - the perception of care-givers that the receivers are others, different and unequal; Paternalism - the patronizing attitudes of the care-givers and; Privileged irresponsibility, the usurpation by the privileged of care resources by giving greater priority to their own needs.

Care and Political Theory

To explain the shifting moral boundaries that have encompassed Care and determined its current status, Tronto turns to historical events and societal conditions that formed the context for the influences on the philosophers who shaped liberal theory. This was a period of transition and transformation with the ending of a feudal order and hierarchical systems of governance. Migration and colonial expansion had separated members of

50 Tronto, Joan, 'Reflections on Gender, Morality, and Power: Caring and the Moral Problems of Otherness," in (ed) S.Sevenhuijsen *Gender, Care and Justice in Feminist Political Theory*, University of Utrecht, Heidelberglaan, The Netherlands, 1991.

51 Tronto, J. *Moral Boundaries*, Westview Press, Boulder, Co, 1993.

European families by enormous distance. Concerns were no longer confined to the local or national but passing beyond these longstanding arenas to a global sphere. Tronto argues that these changes forced moral philosophers to move from a contextual morality to a universalistic morality, on the assumption that human reason did not differ. The strength of universalistic morality, according to Tronto, is that it "maintains a strict boundary between politics and morality." (p.148) Liberal theory with its emphasis on universal rights and rational thinking also arose in these times. Although ostensibly it was the economic order that had changed with the passing of feudalism, social life was deeply affected.[52]

Tronto asserts that the practice of care she has developed theoretically is both a moral and political concept. Two features of her political contextualization of Care are important here: the tension between dependence and autonomy, and the public-private dichotomy. Political theorists tend to be suspicious of any concept or practice that leads to dependence and a reduction of autonomy. Care cannot be described solely in terms of dependence, even if that condition is manifested in many caring practices. Tronto suggests that Care should be viewed in terms of interdependence. Because Care is an integral aspect of private and public life, she argues that political notions of Care would force a re-examination of the dichotomization of the public and private spheres, which tends to obscure women's lives and contributions.

An important aspect of Tronto's theorizing of Care is her adherence to justice and liberal egalitarian principles, which she links to the democratic functioning that is essential for the right practice of Care.

"The only solution that I see to these two problems (paternalism/maternalism and parochialism) is to insist that care needs to be connected to a theory of justice and to be relentlessly democratic in its disposition. It would be very easy for nondemocratic forms of care to emerge. What would make care democratic is to draw upon two elements of the theory of care that I have already mentioned: its focus on needs, and on the balance between caregivers and care-receivers. (Tronto, 1993; p.171).

It is questionable whether Tronto's conceptualization of care theory can be applied within a liberal egalitarian framework, without encountering its sharp

52 Even as the market forces changed the family composition and the interactions among members, the public sphere was affected by the expansion of state institutions. Citizens once active in civic republicanism–the defense and administration of their towns and countries–were replaced by hired functionaries. Finally the growth of science and technology in this period was accompanied by the emergence of experts whose surveillance and regulatory actions penetrated aspects of local life once impervious to external interference.

divisions between public and private. As a political theorist she is reluctant to discard the justice framework, the foundation for democratic governance. The evolution of socialist feminist thinking in a body of literature and practice that is called gender and development offers a Care perspective within an alternative political economy framework.

Feminist Economists & Care

Socialist feminist theory offers some of the earliest critiques of the multiple forms of labor in which women are engaged. In theorizing women's reproductive activities, feminist economists distinguished between social reproduction and what Folbre calls "caring labor"(labor involved in caring for those whose dependency arises out of age, health status or chronic conditions).[53] Examining the impact of globalization on Care, she notes three major consequences. Firstly, the increased need to work outside the home has made it necessary to purchase Care services in the market, where once it was produced at home. Secondly, the changing nature of market transactions has made the market more distant from the communities it serves, devaluing relationships and increasing reliance on families for emotional support. Thirdly, the detached markets have reduced the availability of caring labor in contradictory terms. While it has helped to move women away from patriarchal controls in the family, it also burdens women with the tasks of caring, uncompensated, for those who are outside the market.

Like Tronto, Folbre's definition of Care stresses responsibility. Because the economistic term, "caring labor,"does not capture the essence of care, she uses "tender labor of care" to convey the emotional ties which are often part of caring work. She argues that Care requires "reciprocity" and "empathy", which it also creates. To her Care is essential for the development of human capabilities and is expressed through skills and preferences such as the propensity for self-denial or differed gratification. In keeping with the Gender and Development perspective, she argues that societal norms and values should be "reconstructed", so that increased childcare responsibility can foster caring qualities in men. Currently, US family policies "socialize many of the economic benefits of children while requiring parents, mothers in particular, to pay most of the costs."(p. 16) Like Tronto, she sees race and class conflicts superimposed on gender divisions, so that welfare measures lead to different outcomes for different groups.

53 Folbre, Nancy "Care and the Global Economy,"draft background paper for the 1999 Human Development Report. October 30, 1998.

Folbre discusses the tension between individualism, fostered by the spread of neo-liberal values through globalization, and community/family needs for care in graphic terms:

"At the same time, it is important to face the spectre of McWorld, a fast-care society in which individuals buy cheap, standardized, pre-packaged units of supervision, instruction and therapy. In a world of spot markets and instantaneous transactions, there is little room for the development of solidarity or affection. If more and more individuals opt for an individualistic strategy that emphasizes autonomy over commitment, the costs and risks of commitment will increase. The result can be a bit like an arms race, in which individual efforts to gain strategic superiority lead to a tremendous waste of social resources and, ultimately a destructive war of all against all."(p. 22).

The recurring theme of the clash between justice and care, that mark the debates following the publication of Gilligan's work is echoed here, in the futuristic vision of an economist familiar with the behavior of markets and exchanges. Folbre sees the increasing movement of Care functions into the market as a manifestation of the "commodification of care". She warns that the unregulated competition associated with globalization "will almost certainly erode families and communities along with nation-states." (p. 21) While she does not propose a solution, Folbre draws hope from the "growing evidence of international feminist mobilization around care issues."(p. 23).

QS Case: Background & Discussion

The government of Vietnam stopped QS trials after the WHO advisory warning against the drug's use. Elsewhere in the Third World, particularly India and Chile, governments supporting free market principles (capitalist/neo-liberal paradigm) intervened to stop the drug's use only after women's groups mounted a strong and sustained protest ranging from demonstrations to major lawsuits. In India, the women's movement played a leading role in bringing the abuse to public attention, initiating action and maintaining pressure on the government until it acted. While individual women and local groups demonstrated outside the clinics of Dr.Mullick in Calcutta and Dr. Kini in Bangalore, the impetus for action came from New Delhi–based groups. The national women's organization, AIDWA, and public health faculty at JNU took legal action. They were supported by Saheli, an autonomous feminist collective and longstanding campaigner against abusive and dangerous contraceptives and other groups. The plaintiffs filed a public interest lawsuit in the Supreme Court seeking State accountability for the spread of QS within the country. The "defendant" in the lawsuit, Dr. P.K. Jain is a businessman and doctor, who runs a television business and is a former Member of Parliament representing the party of Hindu fundamentalism, Bharatiya Janata party (BJP), which headed the Government of India during most of the period covered

by the trial. (India's Supreme Court refused to hear testimony from Mumford and Kessel in support of Jain.)

Indian Political Economy

To understand the quinacrine case, we must view the political economy of India and the factors that contributed to its ban. It is also necessary to take account of the players and the historical period during which the drug was diffused. In July 1991, the government of India accepted a multi-billion dollar loan from the IMF, changing at once the economic history of a nation committed to socialist planning for over four decades. With the loan came the mandate for structural reforms, the opening up of the economy to liberalized trade and investments from abroad. Restrictions on the import of cosmetics and drugs were lifted, and the Indian market was flooded with consumer goods treated as contraband during the years of rigid import regulations. Bhatt discusses the laissez-faire growth of the private sector, the declining authority of the State to intervene and the passivity of medical associations and councils charged with monitoring the quality of care in private practices.[54] Five years after the economy was liberalized the reach of the 1986 Consumer Protection Act (COPRA) was extended to include private medical practice. The COPRA set up consumer forums and councils to highlight and discuss consumer interests. A major topic for these bodies, locally grounded, is medical negligence – an issue relevant to but not at the center of the quinacrine controversy, which questioned the legality of the procedure. The unregulated growth of the market in India facilitated the forays made by Mumford and Kessel and their ability to recruit gynecologists for using the drug in their practice. A Patiala (Gujarat) based OB/GYN recruited by the two Americans was an office bearer in the national Indian Association of Obstetricians and Gynecologists.

The liberalization of the economy, resulting in increased deregulation and privatization of the public sector, does not fully account for the spread of QS in India. The Indian State has long viewed female fertility control as the cornerstone of its family planning. Since the introduction of a national family planning program in 1955, the family planning budget – once a fraction of the health budget – has enormously expanded to the detriment of the allocations for health. Highlighting this problem, JNU's Imrana Qadeer criticises the declining resources for primary health care, which has progressively undermined the health status of disadvantaged groups.[55] The skewed

54 Bhat, R. 'Regulating the private health care sector: the case of the Indian Consumer Protection Act, *Health Policy and Planning*, 11(3): 265-379. 1996.

55 Qadeer, I. Brave New World of Primary Health Care, *IASSI Quarterly*; vol. 14, nos. 1 & 2, 1995.

allocation of resources reflects the long-sustained neo-Malthusian ideology at all levels, especially among health professionals and lower level paraprofessionals. The use of unethical practices such as incentives and quotas for health promoters in the family planning program gave rise to coercive and deceptive tactics that violated women's human rights and bypassed informed consent.[56] Finally, the promotion of QS and its acceptance by medical personnel in India fits well with the capitalist paradigm's two major perspectives: free market systems and neo-Malthusian ideology.

The Players

We will briefly examine the major social and political actors in the QS episode, noting their political affiliations.

Indian Women's Movement

The Indian women's movement was represented by AIDWA, one of the largest politically affiliated organizations with a membership of 3.5 million and a long history of mobilizing women to protest and press for policy changes. In her history of the movement, Kumar documents its growth from the colonial period onwards.[57] Kumar distinguishes between the true women's movements such as the communist-led food campaigns of the 1940s; Chipko, the anti-alcohol and anti-price rise movements of 1970s and those which were primarily dominated by men, but in which large numbers of women were active.[58] Distinctions must also be made between the women's wing of the political parties and the autonomous women's organizations (AWO), which tend to be attuned to western feminism.[59] Relevant here as well are movement activities against the introduction of abusive and dangerous contraceptive technologies and the opposition to the growth of misogynist fundamentalist forces within the country. Members of the Forum against Oppression of Women, in Bombay, are active in both national and international women's networks and set their agenda according to the larger feminist community. However, in domestic matters, they do not command the resources or the reach of the politically affiliated groups. Forum took the

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56 Hartmann, B. *Reproductive Rights and Wrongs*, South End , Boston. 1994 (2nd edn.).

57 Kumar, R. *The History of Doing*, Kali for Women: New Delhi, 1993.

58 There is a large and growing body of essays and studies of the movement, which are not included here. See Gail Omvedt, *We will smash this prison*, Zed Books, London. 1979, A. Basu *Two Faces of Protest*, Oxford University Press, Bomba, 1993, N. Gandhi & N Shah, *Issues at Stake*, Kali for Women, 1992. I use the term Indian women's movement to include all subgroups, including a significant health-oriented group of women and men.

59 Ray, R. "Women's Movements and Political Fields: a Comparison of Two Indian Cities," *Social Problems*, Vol. 45, no. 1 Feb. 1998.

lead in protesting misuse of prenatal diagnostic techniques for sex determination, winning a symbolic victory when Maharashtra state passed a bill banning the practice. It also led successful protests against the introduction of Net-en, a contraceptive banned in the West.[60]

The rise of the movement is closely interwoven with the latter day history of post-independence India. Agnihotri and Mazumdar fill a broad canvas:[61]

"In contemporary India the resurgence of the women's movement and its contours have to be seen in the light of: (1) The crisis of state and government in the 70s going into the emergency. (2) The post-emergency upsurge in favor of civil rights; (3) the mushrooming of women's organiza-tions in the early 80s and the arrival of women's issue on the agenda; (4) The mid-80s marked by fundamentalist advance (5) The 90s, when the crisis has deepened with regard to state, government and society."(P. 7).

Pathania points out that the disenchantment with the liberal model that emphasized women's equality under the Indian constitution and the undelivered promise of economic development improving women's status led to a new perspective. She states that the "recognition and defence of women's freedom and dignity as human beings" became the guiding principle of the women's movement.[62]

As the women's division of the Communist Part of India (Marxist) AIDWA works within a political ideology that opposes class interests and mobilizes women to both entreat as well as challenge the State. The CPM was a supporter of the United Front government, which held office briefly (1996-97). In 1997 the growing power of conservative forces in the country was symbolized by the victory of the BJP-led coalition. The fundamentalist ethos, inimical to progressive groups, provoked resistance from left-leaning groups. AIDWA's decision to challenge the government and the private practitioners such as Dr. Jain, who were using quinacrine, should be viewed within the larger political context. The alliance of these groups against contraceptive sterilization is noteworthy, considering that AWOs like Saheli had taken the lead against the introduction of Norplant and the anti-fertility vaccine. While Saheli members worked with the plaintiffs and produced a monograph (Quinacrine: A

60 Ray, Raka, *Fields of Protest*, University of Minnesota, Minneapolis, 1999. Pp 140-151 (Ray presents the Forum as an in-depth case study of a Bombay-based AWO).

61 Agnihotri, I. and V. Mazumdar, "Changing the Terms of Political Discourse", *Lokayan Bulletin*; 12: ½, 1995. P. 7.

62 Pathania, Sunita "Women's Movement in Haryana: Problems and Challenges", in Raj, S.L. and Roy Choudhury, SJ Arundhuti, *Contemporary Social Movements in India: Achievements and Hurdles*, Indian Social Institute, New Delhi. Pp126-127.

Sordid Story), its role was overshadowed by the news coverage given to the plaintiffs. Political and economic conditions have determined the group that would assume leadership of the women's movement in its response to a market economy permitting the entry of Quinacrine and its promoters.

Dr. Jain: Dr. N.K. Jain responded to the women demonstrators outside his clinic by sending a press release defending his use of quinacrine. Linking patriotic fervor with neo-Malthusian concerns about population growth, he accused his opponents of distorting the facts about Quinacrine Sterilization. He emphasized its safe track record, its cost-effectiveness (Utilitarian rationale) and power to make the procedure more equitable. Rao attributes the time lag between the Supreme Court order to ban quinacrine and its notification in the Gazette to the tactics of the former BJP MP who wielded considerable influence with the government.[63]

The success of the women's movement in raising public awareness and litigating against the drug must be viewed within the context of the current Indian political economy, representing the struggle between capitalist and socialist political ideologies. The international women's movement played a facilitating role, although it was the national movement that took direct action against the QS promoters. Referring back to Tarrow's distinction between issue-based networks and social movements, it should be pointed out that the International Women's Health Movement has been active for two decades and meets periodically to confer about women's health status and take action. It is a collective body that functions across issues and sustains long-term relations.

According to social movement theory, reviewed earlier, movements aim to change policy, process and societal values. In the Quinacrine case, the women's movement clearly created a policy in the absence of an appropriate regulation. It entered the process by filing a lawsuit that received enormous media coverage-both print and electronic. It is difficult to evaluate changes in societal values without a formal study. The Supreme Court judgement, however, clearly warned the public that the market for unapproved drugs was closed. Reverting to our problem statements, we must admit that the voices of the sterilized women have not been heard. Difficulty in tracing them without access to clinic records (or in their absence) as well their need for secrecy make the task formidable. The judgement of the Supreme Court was widely hailed by the international women's movement and progressive groups in the country.

63 Rao, Mohan. Quinacrine Sterilizations Banned, *Political Environments*, No. 6, Fall 1998.

Policy Implications

We have examined the philosophical assumptions of liberal theories that have guided the current models of international development and health policy changes, as well as the emergence of a feminist ethical perspective that is more attuned to the nonhierarchical and process-oriented decision-making found in third world women's movements. What are the implications for health policy planning and implementation?

Moser's model of WID policy making for third world women, the empowerment process, is best exemplified by the women's movement in India rather than any particular non-governmental organization. Various segments of the movement have registered remarkable successes in local communities as well as at the national level. The ban on QS in India and Chile represents the accomplishment of strategic gender needs. In the tuna wars, Tarrow stresses that that although transnational collective action can address multiple audiences in different regions, spreading information and gathering support, the decisive action is at the local or national level. The international women's health movement must strategize to offer more support to women in their own settings rather than pursue mainly international agendas that do not filter down to women at the grassroots.

At a law symposium, Moser proposed a methodological framework for gender planning to determine the "appropriate entry points" in terms of health issues for women to take action. She raised three sets of issues: First, the identity of the individuals whose rights (health) are at stake and the identity of those who have needs. Importantly, the level of involvement of the women in defining their own rights/needs. Second, she raised the issue of how change is achieved – through bottom-up processes of empowerment, or top down hierarchies. The third issue was the importance of separating gender-based issues from women's issues.[64]

Moser's empowerment approach to policy making for Third World women must be broadened to incorporate the struggles of women's movements against fundamentalist and market forces as well as the pervasive neo-Malthusian ideology. Policy analysis of political, social and economic phenomena should incorporate the disposition of social movements and their influence over policy elites. Increasingly, these movements are assuming a large role in the absence of State interventions and in the face of the erosion of the public sector.

64 Moser, C. "Gender Planning: Different Policy approaches to reproductive health", *The American University Law Review*. Vol. 44. 1113. 1994.

How does the ethic of care fit Moser's framework? Studies of the women's movement member organizations emphasize the non-hierarchical nature of these groups, their democratic governance, solidarity with women of all classes, castes and culture, and their commitment to fighting against oppression of any and all women. These characteristics, which typify feminist culture, are also representative of the requirements for caring practices that Tronto outlines. Brinda Karat is presently engaged with members of her group in trying to track down the women who have been sterilized at Dr. Mullick's clinic, in spite of having been denied governmental support and funding for this task. AIDWA has assumed the responsibility for this task, symbolically asserting the rights of the women.

As Tronto points out, the rejection of liberal philosophy by progressive women's groups in the third world countries, as well as in the industrialized nations, creates a vacuum that Care theory can fill. Care theory offers a feminist approach to re-conceptualize the dominant liberal paradigm and address longstanding inequities suffered by women and individuals of different race, class and ethnicity. Tronto sees Care as a way of circumventing the fragmentation of women's interests through identity politics. It also provides a new political vocabulary to include those traditionally excluded by legitimizing their voices. Finally it helps to re-mould justice theory by reviewing individual and societal values.[65]

Moser's addition of the role of community work to women's traditional productive and reproductive work offers a way of incorporating care into her model of policy-making. Because caring work is more than community commitments and includes social reproduction, it is important to enlarge the conceptual dimensions of the triple role she has proposed. Such an effort needs to be within the framework of the gender and development model to which socialist feminists like Folbre have contributed. Women's movements have shown that the empowerment process – organizing at grassroots to take action – can address all kinds of needs, practical and strategic. It is also an assertion of women's rights and concerns, demonstrating that justice and care perspectives are compatible and can be addressed jointly.

65 Tronto, J. "The Question of Justice and the Nature of Caring in Politics", in *Gender, Care and Justice in Feminist Political Theory*, University of Utrecht, The Netherlands. Pp. 21-35.

This paper establishes a foundation for interweaving multiple theoretical perspectives with the feminist ethics of care to enhance the Moser WID policy model for third world women. Folbre has convincingly argued that such an integrated model is applicable to help reduce the impact of globalization on their health and well being. ■

16 Human Development, Population and Poverty: Crises, Dilemmas & Choices for India

Shobha Raghuram*

While our cities and towns require to be looked after much better than they are at present, it is really the village that has been terribly neglected and cries loudly for succour. Public health must, therefore, go to the village, and the village should not be compelled to come to the town in search of it. Our community development movement will, I am sure, play a very important part in this extension of public health services to our rural areas. ... These nine and a half years since Independence have been vital years for us, the change-over from foreign rule to self-rule, the adaptation of the old order to the new order, the many new problems that faced us and the approach to these problems from the point of view of the interest of the masses of the country, the growth of planning and our Five Year Plans, the special attention to industry and agriculture, the question of unemployment, and the basic question of our fight against poverty and of changing a static and stagnant economy and making it dynamic and self-reliant. From Foreword by Jawaharlal Nehru, in Borkar G., 'Health in Independent India', Ministry of Health, New Delhi, 1957.

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Introduction

During the last decade some of the most powerful critiques examining the legitimacy of inherited ideas on the relation between population and development have come from economists, policy makers, grass-root women activists, and social scientists. This plurality of critiques, mounted from diverse theoretical perspectives, have questioned and re-framed the extent and validity of the linkages (casual and deductive) between these areas, which had hitherto been claimed to be true. These critiques include:

1. The "Welfare" role of the nation-state in the surveillance, control and regulation of the population;

2. The environment-population debate taken to mean quantitative resource allocations, consumption, and sustainable development;

3. Population as a discipline that comprises data banks on size, structure, distribution, density, growth, fertility, migration, and the social consequences that follow from such a system of classification and analysis;

4. Reproductive technologies as means of control, market-dictated, and central to North-South politics.

5. Population growth and control in the politics of development strategies for eliminating poverty, promoting and safe-guarding human securities, and people-centred development.

Although the percentage of people below the poverty line has decreased the numbers of the poor have increased. Poverty is a state of beingness from which people are unable to emerge. The darkness is known and understood only to its survivors. There is no end to the studies on poverty but the political will to eradicate poverty has not been commensurate with the understanding of it as evidenced in a large number of available studies. Human development indicators show that the issues of Human Development, Population and Poverty have grown in significance in a world divided both globally and nationally. In 1992 the poorest half of the world, accounted for less than 15% of global GDP. Conversely, the 15% with the highest incomes accounted for over 50% of global GDP. After 50 years of Independence, and despite advancements in various fields, India stands today with a dismal record in several social development sectors. Close to 37% of India's population,[1] i.e., nearly 329 million people, live below the poverty line. We have a polity that has well over 450 million people without access to the written word. The literacy of women is at the appallingly low level of 39.42%, with only 21% of rural women being literate. In UP, Bihar and

1 Centre for Monitoring Indian Economy (1996), India's Social Sectors, Bombay.

Rajasthan female literacy is at 9% among scheduled castes and 7% among tribal populations.[2] The lack of health facilities in rural areas has made the maternal mortality rate (MMR) of rural women in the 15-45 age group particularly high at 12.5%. India's MMR rate is 50 times that of developed countries. Virtually half of the world's child labourers live in India. If you consider the female labour force, then Indian women contribute a much larger share of their earnings to basic family maintenance in the 60 million Indian households that are still below the poverty line. Only 5% of rural households have access to sanitation facilities. Women form the largest body of unskilled workers, being 90% of rural and 70% of urban unskilled workers. The deaths of young girls exceed those of boys by almost 1/3rd of a million every year in India. 60% of the 50 million urban poor are women and children. On all the counts of income, education, mortality, morbidity, health, violence, political participation, access to water and electricity, and sanitation it appears that women have had to shoulder extraordinary burdens of both inequitable development strategies and skewed sets of power relations.

Table No. 1

Other Population Features 1970-93				
Indicators	*Unit*	*1970-75*[1]	*1980-85*[1]	*1988-93*[2]
Density	inhab/km²	188.8	232.1	267.7
Annual growth	%	2.2	2.0	2.0
Fertility index	births/woman	5.4	4.5	3.7
Infant mortality	per 000	132	106	80
Life expectancy	year	50	55	61

Source: World Bank, India Country Economic Memorandum, 1995
1 Latest single year
2 Most recent estimate

The Crises

The crises in development strategies have become acute. The growing despair about ever arriving at an acceptable quality of life for all her citizens requires serious attention and the political will to change for the better. These crises do not plague

2 Census of India, 1981 (1981), A Portrait of the Population of Bihar, Registrar General, New Delhi.

India alone; several societies are acknowledging common problems that straddle issues of human welfare, accountable governance and demographic pressures. We require a refurbishing of state-led policies for coping with these problems and for finding resolution-seeking directions. Malthus published his 'Essay on Population' in 1798, exactly 199 years ago. His alarmist position that the more rapid the economic growth the greater the increase in the fertility rate has certainly been disproved: Economic security and greater accessibility to education opportunities have certainly brought about sharp declines in birth rates. "In the first century after Malthus resistance to discussing population control came from other sources, principally from the social pioneers who were reshaping European culture into a more humane one. Reformers who were trying to persuade society to deal compassionately with children, women and the poor often considered population a distraction."[3] The population issue for North countries also echo neo-Malthusian fears, quite often alarmist in nature triggered by the pressure of mass migrations and its attendant consequences on employment, racial, ethnic tensions etc. This has been particularly evident in most international negotiations. E.g. at the ICPD, Cairo, 1994, wealthy industrialised western nations wanted a deletion of the 'right of migrants to reunite with their families' and did not want it to be made a principle. Third World countries however demanded the right for their migrating labour to cross borders.

Within countries, however, there are severe variations which remind us that, for all the popular language of globalisation, to discuss population is to tackle inequitable growth and marginal income distributions. We must also account for the barriers that divide the world, both between countries and within national borders: No lives are lost because of pregnancy in Europe, N. America and Japan, but almost half a million women in Africa, Asia and Latin America die during child birth every year. Out of every 1000 babies, 73 die before they reach their first birthday. Delivery by untrained persons, short intervals between births, unsafe drinking water, high incidence of diphtheria, measles, TB, polio and respiratory illnesses have all contributed to a high rate of post-natal mortality. Women die in unsafe abortions and yet the demographic discourse hardly captures the high stakes involved in nation-state interventions in family planning and population control. However, what has drawn greater attention among policy makers is that, between 1980 and 1990, the world population increased by 923

3 Hardin, Garrett, 'Living Within Limits; Ecology, Economicsa and Population Taboos,' OUP, Oxford, 1993. p4-5.

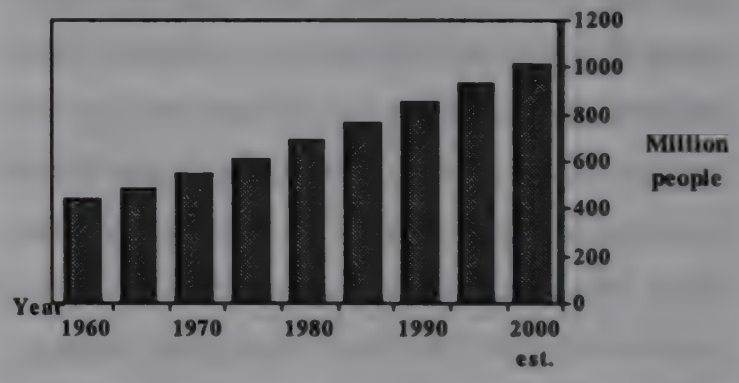
million; Asia, with an increase of 517 million, accounted for more than half this figure. India is the second-most populous country with an annual addition of 10 million people and likely to cross the 1000 million mark just as it enters the 21st century... It is interesting to note that in 1952 India became the first country to promote family planning as an integral aspect of development activities, underscoring thereby the triage of population growth, development and the need to safe-guard the environment. However, the target, of arriving at a birth rate of 21 per 1000 by 2000 AD set in 1983 in the National Health Policy Statement has been progressively postponed in every Five-Year Plan.

"Soon after India attained independence, the newly constituted Planning Commission, while formulating the First Five Year Plan (1951-56), recognised the importance of laying down a sound population policy. A provision of Rs.6.5 million was made in that plan ... The money provision in the Eighth Plan is by an odd coincidence, exactly 10,000 times (Rs. 65,000 million) as much as in the First Plan."[4]

The draconian measures of the Indira Gandhi regime in the 70s created deep national resentment. China's forerunner state policy of a one-child norm later on only reinforced the popular belief that the target setting exercise destroys the individual's autonomy in regulating his/her autonomy and making choices in terms of human happiness.

Table No. 2

Estimated Indian Population 1960-2000



Source: World Bank, India: Trends, Issues and Options, 1990

India's professed commitment in the Five-Year Plans to the eradication of poverty has not been commensurate with her performance in accelerating human development. The burdens of poverty are many: The multiple deprivations that characterise poverty, including inadequate literacy, safe drinking water and nutrition, require urgent solutions and reforms in public policy.

4 Antony T.V., "The Population Explosion of India - Can it be Controlled: The Tamil Nadu Experience", Monograph, Madras, n.d.

"Literature is replete here with images of reproductive profligacy of the poor in India. In much popular understanding, this is frequently adduced as the cause of poverty of the poor and indeed of the country. From travellers such as Abbe Debois early in the 19th century, to Census Commiss-ioner of 1891 and indeed to even the Bhore Committee Report, this motif is constantly refurbished. For instance, as it went on to recommend a family planning programme for the country, the Bhore Committee noted: The classes which possess many of these undesirable characteristics are known to be generally improvident and prolific. A continued high birth rate among these classes, if accompanied by a marked fall in the rate of growth of the more energetic, intelligent and ambitious sections of the population, which make much the largest contribution to the prosperity of the country, may be fraught with serious consequences to national welfare ...(GOI, 1946)."[5]

Rao in fact goes on to argue that the higher burdens of infant and child mortality lower the rates of child survival thus in fact leading to the poor in India having the smaller family size. This has been based on the findings of a study in Madhya Pradesh. But to perceive population growth as eating into already scarce resources and to hold the poor responsible for not reducing the fertility rate is to avoid and distort the issues of unequal rates of consumption of the rich and the poor, and the skewed distribution of the benefits of development. A large set of variables inform the state of affairs, e.g., child-birth related complications account for 15% of all deaths among women; and the discrimination against the girl child is responsible for the deaths of 1 out of every 6 infants. This might well make us conclude that the only reliable approach to keeping the population growth at an acceptable level is one that focuses steadfastly on what Amartya Sen calls the 'co-operative' approach, i.e., to escalate the delivery of basic needs and services such as primary health-care, improved sanitation, economic opportunities, basic compulsory education, and the availability of safe drinking water. Sen lists the services and needs under the rubric of the following: economic security, basic health care, life expectancy, basic education, political and economic stability. However, even the 'development is the best contraceptive' approach is not enough, especially in a country where the maternal mortality rate and female foeticide are not taken seriously by policy makers, with their almost fatalistic response to growing systemic violence. Mortality rates reflect sharp gender differences.

5 Mohan, Rao, 'Myths of Reproductive Profligacy of the Poor: Evidence from Madhya Pradesh District", Economic and Political Weekly, June 21st, 1997.

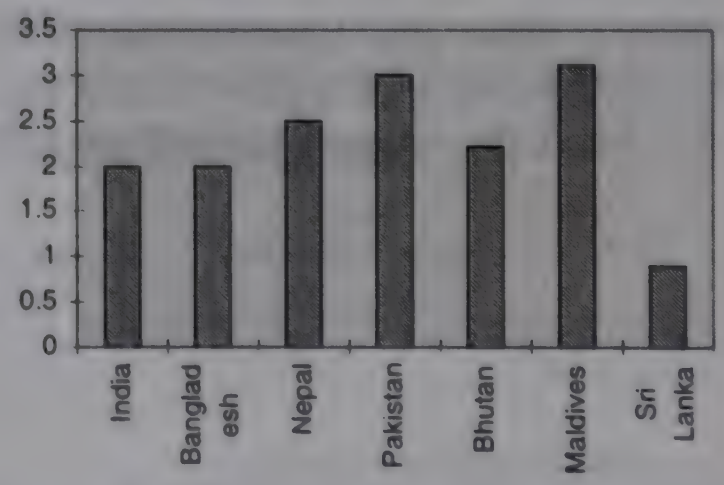
The Role of the State

In official circles there is an excessive preoccupation with contraception and sterilisation. Much less effort is spent on confirming in policy the far-more-important relations between education and fertility, and the need for women to have access to information, which is critical to their well being and to their status as equal citizens. Women are being targetted in more ways than one, thus aggravating the heavy load of reproductive morbidity borne by them. Leading multilateral institutions have provided large sums of money for population control in India. Women in free-trade zones in Indonesia are being experimented upon with injectable contraceptives; and test trials have been on in India since sometime now. It is a world of unfree speech and unfree life contexts. The right to information is repeatedly suppressed by governments. What women and populations need is more access to information, and the political rights of citizenship rather than technologies that leave little choice other than more consumption of these contraceptives in place of a self-determined existence. Take, e.g., the Indian population policy: The family welfare programme is at present vertically structured. The Constitution of India states that "Health is a state subject" and that the responsibility for the implementation of all health programmes rests with state governments. The programme needs to be entirely decentralised, made transparent with democratic planning for the delivery of health services in rural and semi-urban areas. The programme is largely contraception oriented. It aims sterilising 5 million annually. It aims at persuading another 20 million or more acceptors to adopt other forms of contraception. It has often been buttressed with official provisions of incentives for those who undergo surgical interventions. Incentives also come in the form of monetary compensation. It is, therefore, not surprising that the status of women's reproductive health and rights corresponds with their subordinated social status: Literacy rates, sex-ratios, the availability to health care and education, and nutrition are all matters of severe neglect and distortion in public policy.

India's population woned cross the 1 billion mark at the turn of the 21st century. Demographers predict that, going by the trends in both countries, the population of India will be higher than that of China by 2040. Within the South Asian region India appears to have stabilised.

Table No. 3

Population Growth Rate



Population Growth Rate

Fifty years ago, the leaders[6] of India's struggle for independence advocated state involvement in bringing about a modest rate of population growth. However, as has been observed by many, Gandhi himself had contradictory opinions on the issue of family planning: In 1925 he wrote that India, with the help of proper land usage, better agriculture and supplementary industry, could afford a growth in population; two decades later he cautioned against artificial methods but, at the same time, announced, "the propagation of the race rabbit-wise must be stopped"; and in 1935 he said he did not believe in having any children ! Many commentators have put this down to ambivalence; but it is also true that population then was viewed more humanistically than now. The confused ambiguity was not without its benefits. (Despite the ambiguity progress was achieved. In 1941 the life expectancy in India was 32 years, now it is 58 and 64.9 years in rural and urban areas, respectively.) The critical temper of newly independent India was devoted to promoting policies that would build modern India on the principle of equality, heavily promoted by the state through its multifarious development interventions. The state, however, faced the limitations of a single national policy that could not cover with coherence a country as variegated and as diverse as India.

For example, observe the following wide regional variations:

- the estimated average maternal mortality rate is 234 (per 100,000 live births); however, in Assam it is 1028 and in Uttar Pradesh it is 931;
- the total fertility rate in Kerala is 2 whereas in Arunachal Pradesh it is 4.25;
- the mean age at marriage is 25.1 years in Goa and 17.4 years in Madhya Pradesh;
- the four states with the lowest human development indicators – Bihar (80 million) Rajasthan, Madhya Pradesh and Uttar Pradesh (160 million) – account for 40% of India's population, with almost 50% below the poverty line.

It is pertinent to note that these wide regional differences make it fairly difficult for one successful policy to govern all contexts. The important determinants of demographic behaviour are fertility, mortality, composition and the distribution of population. These determinants are also

6 Borkar G., 'Health in Independent India', Ministry of Health, New Delhi, 1957.

privatisation of health care. The net result is that the state's responsibility towards an effective health-care system for the poor is a waning dream. And there is a perpetuation of the long-standing view that it is quicker and easier to coerce people, particularly the poor in the third world, to consume reproductive technologies and keep in check their ability to reproduce rather than to set in motion long-term policies which can radically cure the imbalances that divide the world. The growing privatisation of health care in a country where ill-health is part of the daily life of its masses, has certainly meant that the poor are pushed to the fringes of survival. Protection against communicable diseases, access to the means of controlling fertility, having safe water to drink, and the right to reach at least some form of health care quickly and with minimal cost and the assurance of attention and medicine are all inalienable and inviolable rights of every citizen. And yet by allowing the health care services for the poor to deteriorate it is a clear demonstration by the state that the poor are dispensable. There is a synergistic interaction between malnutrition and infection, between poverty and ill-health, and between ill-health and sexist politics. The bottom line in this scenario is to be poor, to be a woman and to be ill. The late economist T.N. Krishnan has estimated[11] that the poorest tenth of the population spend about 10% (Kerala) to 230% (Uttar Pradesh, Bihar) of annual per capita consumption expenditure on health. The top 10% bore 5-40% of annual income. With 65% of government expenditure on health going to salaries it is up to any one's guess to ask, "What is left for the care of people?"

Another unintended consequence is that the official pre-occupation with contraception and sterilisation sidelines the reality of various other factors which also influence fertility such as education, female age of marriage, female literacy, IMR, and the spacing between children. This dimension of neglect implies that basic-need services also develop a unidimensional profile. These undimensional interventions promote the technical world view, i.e., depending now more on reproductive technologies to bring down the fertility rate.

"The fact that with so many economists and planners on the Committee, no cost benefit analysis of the appropriateness of different technologies for a poor country like India was undertaken, is more evidence of the schizophrenia. A NORPLANT costs RS. 2000, which is the medicine budget for an entire population under a sub-health centre. The cost of an imported injection Depo Provera is close to US $30 or Rs. 4000 per year per woman which the majority cannot afford. If

11 See "India: The Road to Human Development", UNDP, New Delhi, 1997.

such contraceptives were provided as a service by the health department these expensive items will compete with essential life saving drugs. Neither can India afford research on all methods of contraception just as its citizens cannot be provided with a menu card for every meal."[12]

The Politics of Technological Coercion

The increasing use of non-terminal methods of contraception, the top-down approach of government planning, and the promotion of these technologies by foreign aid agencies and R&D institutions in population control have all contributed to making population control appear a highly manipulative exercise rather than a problem, which by its very situation requires a more than technical solution. The cut backs in investments for public health have only exacerbated this instrumentalist, technical, dominant world view. Let us observe the prevalent hermeneutics of population control today: Female foeticide, female infanticide, the sites of sterilisation camps, and invasive hormonal technologies such as the six-capsuled, hormonal sub-dermal insertion device called Norplant® or quinacrine. (used recently in West Bengal and Karnataka). This drug is basically ordinary quinine tablets. When introduced into the uterus it causes inflammation, scarring and mutation of cells. While the WHO recommended a halt to the trials cautioning against the possible carcinogenic nature of quinacrine pellets, medical doctors have with impunity carried out test trials in Calcutta and Bangalore. The contraceptive injectable Depo Provera too has side-effects of BP fluctuations, excessive bleeding, fatigue and other debilitating effects. The medical establishment has taken no collective position on this synthetic compound which mimics the natural hormone progesterone and which disrupts bodily functions when the timing of the administering of the drug is inaccurate. The unsuitability of these drugs to local settings is an issue that deserves sensitive attention from the medical profession. For those like myself working on technology and ethics it is a tragic reminder that markets and practitioners of R&D have colluded in exercises that have involved thousands of women in Vietnam, Indonesia, India, etc. Women activists are developing a large data bank of irrefutable evidence to show the extent of mutilation they are likely to cause. The data being maintained of trials right now leave much unsaid, left to the varies of trial and error. The specious argument that good contraception will bring down the MMR does not have any buyers. Take, e.g.,

12 Mazumdar, Vina, "Globalisation of the Family: The politics of Population Control", Social Change, Vol.24, Nos.2&3, New Delhi, September-December, 1994.

Indonesia where the decline in birth rates through mass forced contraception has not brought down the MMR.[13] Meanwhile various programmes have been devised by international aid agencies to persuade, or rather alarm, populations about the impending disasters of population growth, e.g., RAPID (Resources for the Awareness of Population Impacts and Development). In this major management exercise country models are devised to dramatise the perils of overpopulation with simple graphs, highly selective statistical bases, and elementary Malthusian reasoning.[14]

Conclusion: A Flawed World View

"There is no point, then, aiming for the universal, no point aiming for the heights, since there are no more heights. Erosion has done its work. If there is no longer any possibility of a philosophy of transcendence, since thought has been exiled to the other side of the looking-glass, there is no longer any possibility of conquering power either, since the political has been exiled to the other side of representation. There are no longer any heights to storm, either in the political domain or anywhere else, and the single-handed ocean crossings, which are our modern equivalent of climbing Annapurna, are posthumous fantasies." **Jean Baudrillard, *The Illusion of the End*, Stanford, 1994**

Is this demography, is this family planning, or is it the instrumentalisation of a flawed world view? This is the question we will be forced to consider if we wish to prove one of India's foremost community health practitioners once truthfully declared that "there is no vaccine for poverty" and yet we think that there is one for solving the population crises! The disassociation of the larger predicament of survival from the operationalisation of population control is well captured in this simple protest of a peasant woman, "We have children, not population."[15]

If we were to recall the long term-goals of social equity with justice the issue of population would cease to be a problem dissociated from the lives of men and women. The social movements in their response to the state-led enterprise called population in India have demonstrated with their recent success in getting the government to lift the country family planning targets, that the people of India

13 "In the short term ... reduction of infant mortality does not assure reduction in fertility. Detailed studies of specific populations demonstrate that for every ten infant deaths prevented, from one to five fewer births result. In the short run, therefore, lowering infant mortality may lead to larger families and increased population growth, but in the long run, as more children survive, parents will want fewer children in order to provide them with better nurture and education." Harkavy, Oscar, 'The Ford Foundation's Work in Population', Ford Foundation, New York, 1985, p.18-19.

14 Hartman, Betsy, "Reproductive Rights and Wrongs; The Global Politics of , Population Control", South End Press, Massachusetts, 1995, p. 121.

15 "Caring for the Future: Making the Next Decades Provide a Life Worth Living" Report of the Independent Commission on Population and Quality of Life", Oxford University Press, New Delhi, 1996.

will insist on their freedom to charter the courses of their lives in this most personal of realms.

The social legitimacy of population control had a long innings because it was backed by tremendous financial investment that funded supportive research and policy interventions, market driven and blind to the bodies and aspirations of its users. Now, we need to strengthen critiques of such programmes, propose and build alternatives, and negotiate for changes. Prescriptive policies are more easily written than implemented. The distortions caused in women's lives, in their perceptions of themselves, and in their roles as citizens and workers will not be easy to set right. If we could decode the forces that caused these distortions and make the history of this understanding transparent in social action, then we would have obtained one more political instrument for furthering our emancipation. The social legitimacy of population control may be replaced with the social. legitimacy of informed, democratic choice. Deeply social and existential problems do not deserve instrumentalist and poor quality technological solutions. The modern medical experience has been reduced to the management and institutionalisation of illness.

The official institutional definition and response to population destroys the more fundamental perceptions of life between birth and death, alluded to as "quality of life". All the human development indicators may still be insufficient in approximating the issues of autonomy, of gender and our determinations of it. Similarly, the research on and the development of reproductive technologies should not threaten individual autonomy and needs to be informed by local conditions and constraints. The critique being mounted today from diverse theoretical view points demonstrate, in the last instance, the growing necessity for the construction of normatives to guide development and population exercises. ■

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17 Between the Clinic and the Community: Health for the Hungry?

Vijay Thakur

Introduction

The clinic has been a situation where I have been privileged to be with individuals in pain and suffering, and with some who have come seeking the truth about themselves. The community has been a place where I could experience significant relationships between people, social groups and what is believed to be "illness" and or health.

The problems in attempting to negotiate this continuum, reconstructing the well-being of individuals and the attempt to reorganize social groups, through some personal practice, represents perhaps a common journey of discomfort and through that an increasing conflict between the polity and individuals. Many thinkers have critiqued the conflict between the individual and the polity and I will not try to express my choices here.

At the near end of this journey I can express my gratitude to Philippe Redon who mentored me through the transitions between the clinic and the community and to whom this work is dedicated. I must also express my gratitude to Freres de Nos Freres, which has supported me, with the necessary freedoms, for completing this paper. It is my

hope that a personal search will help to restore to peoples all that they have lost.

The Status of Health Applications in India

One study, with conventional health indices, ranks India a low 21, a pip above Afghanistan. China is ranked 10th in the Asian countries and Australia is ranked eighth.[1] China has only 1.8%(of GDP) as Private Health Care Spending whereas in India it is 18% of GDP. The government spending ratios are inverted, China- 2.0% while India spend 50.7%,[1] of which a major spending is for fertility limitation and administration. If we superimpose these ranks upon age, gender and the categories of our impoverished peoples, then we can perhaps see the malaise of the troika of medical, education and administrative services. Many colleagues and peers argue that the dismal state of affairs in the health services in India predates globalization while some argue that globalization will, in fact, offer the solution. Professional Associations like the Indian Medical Association and the General Practitioners Associations are still working for a reversal of consumer protection laws that surprisingly are seen as a threat. Health administrators in India are burning the midnight oil towards accelerating the privatization of health services. It would be interesting to see if the trends in the research funding and collaborations in the Indian Council of Medical research too reflect this attitude. The trends towards increasing World Bank and other bilateral funding for both National and State Health plans remains to be interpreted. Global health managers like the World Health Organisation, as we shall see later, are institutionally committed to the mantra of globalisation in its varying meters like social marketing, increasing access etc.

Two models of beliefs seem to emerge: one that believes that globalization will automatically improve the citizen's prosperity and consequently his/her propensity for diseases and the other which mirrors the changes in business structures that are being mimicked by the health care service structures.

The Project

Vigilantes, sidestream researchers and activists are, increasingly and perhaps rightfully, alarmed at the impact of modern economic practices and at the risk of halting "progress", are calling for a sincere dialogue.

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1 EUI Health Care Asia 4th quarter 1999. This publication ranks the countries on 9 conventional health indices including demand and supply analyses.

In predicting the fuller impact, at both an intuitive and the empirical level, vigilantes see strong undercurrents of consumerism, as the driving engine of globalisation, and draw attention to the morbid violation of the global ecology. On the other hand the protagonists of global economy portray activism which questions the jaggernaut of globalisation, as ranging from the hysterical to a provocation of guilt or shame, by ill- informed if not self-centered persons. I worry about activism working out its own mid-life crisis.

The anxiety that people will have reducing influence over theoretical economics as the source of their futures is not to be discounted or trivialised; since the omnipotence of ideas in a world bound by instant and engulfing communication webs. However what proof or computational forecasts do activists possess, to anticipate an aggravation of the miseries of social groups, already beyond the threshold of human endurance and perhaps fortitude? What planned changes can happen and will enforce the renewed agenda?

Such questions I dread, not because of the difficulty of the task but, due to the complexities of simple facts of life like health and hunger. I have attempted to construct a set of ideational instruments that may be evolved and applied at micro-social groups levels. I have proposed that periodic measurements with such tools will probably allow a deeper canvas to depict the changes that will constitute our futures.

For a politics, economics and ethics of Hunger there are excellent works available and I shall refrain from rephrasing original excellence here. Health Research remains a matter long discounted in most impoverished countries, namely that of ethics in health and social research practices in India. Some guidelines have been formulated recently by the Indian Council of Medical Research and the Medical Council of India has yet to comment let alone ratify it.

A document by an NGO, C.E.H.A.T.[2] on this issue, and which predates the ICMR statement, was placed for public and academic debate just before the latter was released. I find that both contain serious flaws and limitations,[3] being unreasonably weighted in favour of researchers, while the subject of research is relegated to dim obscurity.

2 CEHAT, Ethics in Social Sciences and Health Research. Draft Code of Conduct, Economic and Political Weekly. February 19-26, 2000.

3 Vijay Thakur. Faust Revisited (unpublished).

Hunger and Health

Hunger is a known, in its fullness, through direct experience while 'health' is experiencable indirectly, only through its absence. While hunger can be eliminated only by externals, health, barring a few inherited limitations is a restoration of an endowment. The commonality, that both hunger and health share is that social systems delimit the possibilities, of both, for certain individuals and groups.

The thesis that I propose is, appropriate depictions of both, the presence of one and the absence of the other are reflections of 'the political'[4] as distributed in sociopolitical groups.

The Field of Enquiry

Our enquiry must happen within not only the social group but within a quasi-concrete field and before presenting the tools let me sketch this field in brief, as available critique and facts, that are public but conveniently censored in official briefs.

1. The Role of Modern Medical Enterprise and Health

Modern Medical enterprise is scarcely a hundred and fifty years old. ' *The status of many societies has been "profoundly modified at the end of the eighteenth century when the health of the population became one of the economic norms required by industrialized societies. . .. Various sites of medical discourse were profoundly modified in the nineteenth century: the importance of the document continues to increase proportionately diminishing the authority of the book or tradition*'.

With the elimination of the need for, or a reinvention of labor, in the modern form of capitalistic economy where will medicine head for? The genuflection that empiricism commands, for itself, exposes the hollowness of the claims of medicine in improvements in health- physical,[5] mental.[6]

Thomas McKeowan, a British epidemiologist showed that the death rates of major infectious diseases, in the UK and Sweden had dropped before the development of

4 Paul Riccoeur in 'Text and Action' attempts to minimise the reflex associations of negativity often associated with the word "politics". The analyses of the intersections between ethics, politics and economics is quite illuminating.

5 Ivan Illich, in his Medical Nemesis reviews medical statistics with another framework of truism and demonstrates there is a negligible influence of modern medicine on physical health.

6 Thomas Szaz initiated the anti-psychiatry movement after his path breaking analyses in 'The Myth of Mental Illness' and subsequent works.

vaccines and of drugs for any of them.[7] Only 15% of medical procedures are known to be effective in terms of impact on health and welfare.[8&9] Modern medical industry has managed to construct an illusion that it has the key to the health of individuals or societies. The visible trend is to construct 'health' as yet another external, to be consumed, assimilated and sustained through a continuum of consumption.

2. *Globalization*

This has been depicted in images varying from the Frankensteinian, a fusion between technology and sociopathy, to the persona of a herald, of a consensual and chimerical messiah. Finance Ministers and market analysts opt for the latter icon while the diminishing bands of 'activists' forecast a reign of the former. But for any theatre to be complete there ought to be third actor, in the drama of "globalization" and this is enacted by Transnational Institutions.

My emotional intelligence and some amount of history, tells me that they are but singularly robotic extensions of financial mangers, with the sole agenda of assimilating and accommodating dissent (read activists). Their ethical and/or technological faces are suspect and the benevolent face is a palsied one. But sentimentalism aside let me yield to the professional temptation to psychologise "globalization".

Is a Psychology of Globalisation Possible? My intention in depicting a psychology for globalization is semiologic and not prescriptive and I will leave the reader to explore the viability of such an enquiry. Probably globalization represents an unresolved civilizational effort at assimilating the cumulative destructive capacity built-up by nations and regions through a regression to a collective infantalisation.

Sigmund Freud initiated a discourse on a generic death-destructive instinct in his Beyond the Pleasure Principle. His work was possibly most intensely studied by Melanie Klien who supports a constitutional basis of oral sadistic and anal sadistic expression. Envy and greed being singular expressions of such a developmental situation.[10]

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7 Fritj Capra in Turning Point makes a serious attempt to depict alternative conceptualisation of health, science and wisdom discusses many of the contemporary philosophies of both science and medicine as a science.

8&9 Ackerknnecht E.W The Role Of Medical History in Medical Education.. Bulletin of History of Medicine.1947. White K.L, Wolfsberg (1982). Evaluation of Medicine. Conference on Economic and Medical Evaluation of Health care technologies.

10 Melanie Klien through both infant observations and work with intensely dysnormatised persons detailed the implications of this developmental phase.

Freud's discovery could be reattributed, and instead of an apposition of "Sex-Death", one could interpret it as a discovery of the apposition between "love and greed-envy". Analyses of commercials competing for brand positions will reveal the exploitation of an individuals propensity for envy or a normatising of greed or an inferiorizing-identification process through stereotypy or endorsements in their design.

For a subtler variety of analyses where *swallowing* is distinguished from *biting* we may refer to the dissenting work of Fritz Perls who details the course for the biology of hunger and its clinical and psychological correlates -' *The destructive tendency, which should have its natural biological outlet in the use of teeth, remains ungratified... Furthermore, this impatient greedy attitude is responsible more than anything else for the excessive stupidity we find in the world. Just as such people have no patience to chew up real food, so they do not take sufficient time to "chew up" mental food'*. (Italics mine)

In televised commercials this is exploited and the viewer "goebbels" down whatever is dished out to him/her. One can perhaps see the manipulation of this necessary aggression in the types of food distributed in famines and nutritional programs especially for young children.

Anyway it may be diplomatic to re-question and research into our universally agreed upon and operationalised paradigms. However we have been warned not to blindly resist globalization e.g. WHO bulletin. In 'Critical Reflection on Global Trade and Health',WHO managers: '*we conclude ..the Public Health Community needs to understand the health ramifications of global trade agreements, and must concentrate on getting its own facts correct so that public health is not used "naively" for other political ends..*.' Is this not the repetitive echo heard everytime someone argues and/or protests against nuclearisation, large dams, ecological threats or protection local employment.... ***get your facts straight!***

It might serve us well if we recall the words of Derrida, '*Electoral respresentativity or parliamentary life is not only distorted, as always was the case by a great number of socio-economic mechanisms, but is exercised with more and more difficulty in a public space profoundly upset by techno-tele-media apparatuses and by new rhythms of information and communication... This not only affects facts but the concept of such "facts".*'

One of the strategies that globalisation deploys in its territorialisation of facts is the discounting of the narrative. Fortunately methodologies available through works of oral history would indicate the folly of ignoring the

significance and value of the narrative.[11] In its treatment of the narrative globalisation will effect a particular kind of an exorcism of affect from depiction of human life and existence. Planning and Programmes in HIV related issues especially in India have been prone to such blunting of affect.[12] So what are the other mechanics of globalisation besides their stated intents, charters and contracts, and the institution of market? The 'fact' that the health- advertisement expenditures in India are about Rs.500 crores and likely to peak at Rs. 2000 crores is possibly an indicator of such mechanisms. At a managerial level globalisation is likely to work towards the minimising of bureaucratic interface between politicians and speculators, businessmen and traders.

At a philosophical level one may see consumerism projected as the point of freedom and for aesthetics one can visualise it as the road to fatigue.

Globalisation and the Marketing of Health Reform

New Zealand has demonstrated the negative impact of reforms on its health.[13] Post reform China, which constructed the most innovative social health care services perhaps in this century, seems to show all the signs of decay and displacement into the "access instead of outreach", "pay for service", mode. Health services have been comprehensively privatized.[14] Bare feet no longer tramp with medical kits in the communes, or villages in China.

In India, the primary health care services are in a shambles after the family planning-welfare programmes were attached to them. The district and tertiary hospitals will possibly suffer the same fate. The Public Health Services and Programmes are gearing for the cost-recovery mode. Corporate Sector Hospitals along with the privatization of medical education is three decades old and National Health Institutes have initiated privatisation of education. Increasingly the more profitable sections of departments of government hospitals, usually occupying prime land in urban centers, are being handed over to private investors.

The cost of modern health: Alchemy which was a handmaiden for medical practice in its new avatar of the Pharmaceutical Enterprise now drives Indian Health care.

11 Marvin R.Goldfried, Barry E.Wolfe, Towards a More Clinically Valid Approach to therapy research, Journal of Counselling and Clinical Psychology, 1998, Vol 1., 143-150.

12 Vijay Thakur. Facts, Figures and Faces. UNDP Regional HIV and Development Programme Workshop, Manipur 1991.

13 Health Care Asia, 4th quarter 1999 Reforms Hurt N.Zealand's Health System.

14 Amartya Sen & Jean Dreze. 1995, India and China. India Economic Development and Social Opportunity.

A lifelong of medico-surgical practice can safely be covered by about 60 drugs. India has about 60,000 formulations in the market with a production that has increased from Rs. 60 billion in 1992-93 to Rs 120.7 billion in 1997-98, this excludes bulk drugs.[15] The Indian Pharmaceutical Industry is said to be about US$ 2 billion, with a projected growth of 14% annually. Indian spending on pharmaceuticals is 40% of the health care cost as compared to 8.4% in the U.S. and 15% in Europe.[16]

One of the biggest success stories of a multinational company is that of SmithKline Beecham Pharmaceuticals, whose net profit stands at Rs. 332 million in1997, of which Iodex had a sales of Rs 586 million.[17] (Iodex, a counterirritant, originally a liniment is now sold as a balm, cream and a spray, is one of the most useless formulations in any pharmacopea and as any orthopedic surgeon will tell you. It was last popularized in the frontier days in the US by macho peddlers in the wagon rolling Wild West, is being sold in India since the last 9 decades!)

Incidentally "facts" revealed that the actual users of liniments were women, the sensations of a liniment are most unpleasant to say the least. Since women were already sold out on "creams", as beauty aids, Iodex was reformulated as a cream to achieve the much-desired slope on the sales graph. The application of Iodex is now converted into a sensual experience or maybe an aesthetic one! Further, Bausch & Lamb rakes its profits not from contact lenses but sunglasses and metallic frames, which was Rs. 462m in 1997-98.[17]

The technology component of health care in the name of diagnostic services, ranging from biochemistry to imaging is cloning from the pharmaceutical industry. The venture of the tie up between WIPRO and G.E Medical Systems is a tip of the iceberg for the future. Starting with Rs. 100 million capital base in 1990 it raked a revenue of US. $5m that year. The Indian market for imaging related equipment is US$ 200million,[17] about 3 times the National AIDS Control budget for 5years of the phase 1 World Bank Loan.

Predictably, with increasing costs, self-medication and off-the-counter sales of pharmaceutical products will ride the tide in Indian Health care scenario, not to mention a predictable increase in the sale of spurious drugs. An increase in self

15 Ministry of Chemicals & Fertilisers, Organisation of Pharmaceutical Producers.

16 EUI Health Care Asia 1st quarter 2000.

17 EUI Healthcare Asia 2nd Quarter 1999. Profile-business opportunities and constraints in India's healthcare sector.

medications will lead to an irreversible change in microbial ecology with antibiotic triggered mutatagenesis. Studies in soil ecology with modern agricultural practices are already raising some alarm of a similar nature.

The shadow costs of travel, cost of escorts, loss of wages and those incurred for seeking health care under the table expenses remain uncalculated, further disfiguring the facts. What mechanism will a nation adopt to monitor these direct and indirect costs? Will these be automatically reflected in the sensex? Will this monitoring be left to academicians? How will this monitoring be rendered devoid of politics? (with apologies to Dr Douglas Bettcher).

If monitoring is to happen at a micro level and with people becoming evaluators then we could say that an ideal state has been achieved. If new facts unfold, especially contradicting the hosanna of globalization and modern health, what is the flexibility in the Big Brotherhood or Bretton Woods Institutions and the political masters?

My personal experience is limited to the influence of WHO and now UNAIDS upon the National AIDS Control Programme, of India during the last decade but I will place these observations elsewhere.[18] The need to evaluate must be directed at the institutions that barter, promote, facilitate and enforce globalization imperatives, simultaneously. Many of these institutions are usually in with a do-good-mission mode and some are harbingers of modern technology and promises of the fruits of their plans for the future.

I guess we will have to wait for some details from the WHO especially since they are seeking active partnership with the WTO, whether it is a device for amnesia towards its older- "Health for All by 2000" slogan or belated strategy towards it should be known.

Maybe at that moment we will decide whether Aesclepuis ought to be replaced by Apollo.

Measuring Mismeasure?

Returning to the metaphor of theatre what ethical role can one define for oneself? It is unlikely that we may be able to alter the script that has already been encrypted. The cliques of bureaucrats, politicians and transnational marauders are cohesive and have too much at stake.

The age of reason is over and has been replaced not by the age of desire but by the age of greed, of the few. With the

18 Noam Chomsky in World Orders, Old and New offers a refreshing analyses of a Washington-centered globalisation.

control of manufacture of facts, and the alienation from acts, our hope is in constructing alternative facts and transferring them to the peoples who in actuality own these facts. This may perhaps be our first task. This communication may have to be with a trust and with the sense of security that they will discover, for themselves alternative regimes, regimes that will be more concerned with sensitivities than sensex, with hunger than with war, with quality of life rather than the quantum of consumption and maybe construct regimes more just and less destructive. In relaying our privileged gaze to the constituencies that seem to become our concern. This is perhaps the only possible ethic for myself.

Reconstruction of Measures

1. *Where is WHO-QUOL (quality of life)?*

Obviously gathering dust in the cold climes of Geneva. We may begin with a revival of the WHO multicentric study with 24 life facets and a 100 item questionnaire.[19] It might be worthwhile placing this instrument at the seismic zones where reside social groups that are pauperized or are in the threshold of pauperization. A sentinel approach may be used to monitor the impact of globalization on the quality of life in that region and its peoples'.

2. *Vernacular Paradigms of Health: a hierarchy of needs*

The second methodology that I propose is a sort of mapping of beliefs, expectations, needs and the benchmark of satisfaction across the strata of a social group and the institutions that order them. A set of identical enquiry centered around health to elicit these subsets say, women, men, children, economic classes, castes, regions, health service providers, administrators, policy makers and planners be conducted. Regions of convergence conflict and gray zones could then be located. Planning and delivery of services ought to begin from the regions of most intense congruence and avoid the region of conflict.[20] The principle of 'zone of proximal development'[21] used in pedagogy may be analogous to what I am suggesting. Impacts of economic changes, quality of services and satisfaction could then be measured across linear time to demonstrate desirable or undesirable products of globalization or the value of

19 Vijay Thakur. Models, Manuals and Madness in HIV/AIDS in India. (Unpublished).

20 Szabo. 1996. WHO (QOLife)Group.

21 Vijay Thakur. Quality in Education. Consultation for The Aga Khan Education Services Conference, Masai Mara 1991.An attempt was made to apply such a method to plan for quality improvement in the school education services in the AKES network. The stakeholders beliefs and expectations , in the AKES network were matched with a multicentric study on indices for quality schools by World Bank.

health services. Besides the criminalisation of health care delivery that is already with us and we may need to map its extension.

3. *Measuring Social Support*

Whether the embrace of globalization by the Indian governments at any given time is at the expense of the disadvantaged or whether it is a process in minimising disadvantage needs to be determined and redesigned, if at all a compromise between militant rejection and docile submission has to be arrived at. If globalisation is accompanied by an increase in social support and the increase in freedom then we can leave the ecologists to battle it out with the transnational regimes. Requirements of social support vary widely, an important minister may require expensive and equipped security, prisoners may require protection against abuse and much of the severe security will mean little here. In a country where populism reigns, social support systems must be a guarantee which is unified at all party-political levels. Not a blanket slogan but local, group specific. Along with the zip and jag of poverty lines which reduce humans to daily subsistence creatures and which do not calculate a minimal assurance of security for future are a little better than pacifiers in the spectacle of misery that occupies much of these regions and nations.

Though many efforts to depict social support or its absence are made what remains to be developed are measures that are group-specific.[22]

4. *Measuring Freedom?*

One could use several material factors like travel averages from residence, movement diagrams, sociometric distance and interaction measurement across, regional, economic, educational, caste status. Distance between vegetative and cultural needs and ability for fulfillment of these needs could be measured. Self-expression, the volume of views that remain unexpressed for x periods and the number of discrete subjective reasons attributed for the same could perhaps be an indicator. *Is an index of human freedom possible?* This method is inspired by the sociometry and related works of Jacob Lev Moreno. The assumption is; that discursive direction and density is an accurate reflection of empowerment or its absence, with the rider that power is representative of freedom. Individual freedom may be measured through analyses of interactional patterns within a network of a social group[23] and the institutions sponsored by the polity.

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22 Jacob Lev Moreno. Who Shall Survive? Foundations of Sociometry, Group Psychotherapy and Sociodrama.

23 National Commission For Women, Govt. Of India. 1996. Societal Violence and Women in Sex Work. This policy reccomendation evolved out of a process of consultations with women in sex work from 7 States and follows a procedure of depiction of social support and its linkage with other issues.

Measurements are repeated over time and shifts are seen as a measure of greater or lesser freedom!

The interactional networks may then be classified for

1. Actor *centrality*
2. Actor *prestige*

The social group could be categorized for its *density (cohesiveness)*, *balance* and the incidence of *isolates*. The tool could also segregate *cliques* from *alliances*.

Family and group psychotherapists are developing methodologies for research and tools like Social Network Analyses, SNA.[24]

Self -support groups, like Alcoholics Anonymous, Survivors of Abuse, People Living with HIV/AIDS, gay and lesbian organisations, sex workers collectives, historical groups like workers unions and co-operatives, could offer valuable understanding to the benchmarking of network development.

5. *Inter-Group Variance*

We need to monitor inter-group differences in health, very analogous to the measurement of the inter-group differences of starvation during famines—whether there will be no differences in 'health' across groups as there was for hunger in the Dutch famine of 1944 which was very widely shared by the Dutch Population[25] or, whether we suffer selectively, like the Irish potato blight of 1845-51? This will have to be seen maybe in an analogous way vis-a-vis health and social status.

6. *Health of the Health Care Practitioner?*

Globally you will find them an unhealthy lot. Physically you will find this group wherever there is perhaps a very high incidence of life-style diseases. So we need to focus on measuring the health of health care givers analogous to the suggestion of Thomas Khun, *'Scientific knowledge, like language, is intrinsically the common property of a group or nothing at all. To understand it we shall need to know the special characteristics of the groups that create and use it'*. We need a sociology and an

24 A.C. Mayer. Caste and Kinship quoted from Louis Dumont 'Homo Hierarchicus'.a) Status ranking on the basis of exchange of food in a Malwa village. b. Pipe sharing.

25 Laura M. Koehly and Victoria A. Shivy. Social Network Analyses: A New Methodology for Counseling Research. Journal of Counseling Psychology. 1998,Vol. 45. No 1. It presents both the historical evolution of such methodologies and also formalises the transactions and the implications of transactional patterns between individuals, groups or other social units. If we are to accept Madeline Albright's depiction of Globalisation as 'open markets, open borders and open lines' (Times of India, report on ASEAN countries summit. 28th July,2000) then this could be tested with such a method. If we believe this slogan the we must see, lesser cliques and isolates and more balance within the networks.

anthropology of health care practitioners, scientists, and medical researchers before we suggest a profile of the health of our nation.

7. A *Problem*

However the problem of history and the problem of culture remains peculiar to many impoverished nations. How to segregate the responsibilities of a democratic state from the historical and the cultural systems and forces, that have a concurrent effect?

The control of culture, and the diversion of history in social groups can be analysed through a valid measure and reflect the intensity with which democracy is lived by both the state and the social groups.

In both cases one is required to detect the institutions and the micro channels through which power and regulation is enacted. We may have to pursue this despite the reality that most democracy states are, in reality or the truth of it, facades rigged up by a conglomeration of fascists. This is more common than what we are lead to believe, in the name of democracy.

Conclusion

At the end of this task I must confess that I feel some remorse at having increased the complexity of a situation that is vexatious and more importantly one that demands immediate redress. Instead of attempting to defend myself from such an accusation I must say that the exciting value of discovering alternative perceptions and possibilities overrides the demand for an immediate pragmatism. However the responsibility imposed by these deliberations requires that I submit some recommendations.

I must caution the reader however that these recommendations are not derived from any of the forgoing discourse and looking for an absent connection may be frustrating.

Specific Recommendations

In a general way I may say that three "things" must be done with a simultaneity. One, to inform people about facts- 'what is globalization?' in the manner that Dr. Bechter suggests. Two, construct devices that sense the shifts as they happen and that may be used to avert foreseeable disaster, and three to enforce with a superhuman vigor the redress of grievance and intransigence which will be inevitable accompaniments of globalization.

Some reflex actions are:

a) Move population limitations from a health concern to a human resource concern and dislocate all related activities and services from health services structures upon which they parasite. With modern birth spacing methods the need for medical

interventions for family size limitation ought to be minimal.

b) Re-implement with a renewed vigor the applicable recommendations of the Bhore Committee Report

c) Legislate and enforce the recommendations of the Hathi Commission.

d) Legislate norms for advertising in public media. What has happened to the WHO's ethical guidelines for ethical criteria for Medical Drug Promotion (1988) or The EEC Directives on Advertising of Medical products? I am sure the WTO will rule against any attempt to facilitate labeling drugs with generic names in India.

e) Reorder undergraduate curriculum to ethical clinical and primary health care

f) Empower Nursing Professional to prescribe a schedule of 40 to 60 drugs. Maybe every chemist outlet could employ a nurse thus certified to investigate, in a clinical sense, every person seeking off-the counter cures.

g) Move the MCI to ban the practice of using non-medically trained sales personnel, the main source of Continuous Medical Education in India, from visiting medical practitioners.

i) Include stringent penalties for off-the- counter sales of drugs.

j) Audit Health Research activities in India over the last four decades, especially those involving export of biological tissues and materials.

k) Audit the functioning of the so called Trust and Corporate Hospitals with the aim of abolishing all tax-subsidies, grants of land etc; and other supports in financing of these hospitals. (Including those with a Research- Center tag, and those managed like family businesses.)

l) Special statutes to protect interests of clients covered by third party payment schemes, or the so-called health insurance schemes

m) Maybe, obtain an injunction from the Election Commission, GOI, that panchayat and mandal elections must not be sponsored by national or regional political parties. All the grand ideas of decentralization of power and the panchayat as a panacea will come to naught once the political parties spread their tentacles into panchayat formation.

n) It will perhaps be to our loss if we focus on the fates of India alone and exclude the nearest neighbors' - health, from within our gaze.

o) If possible reinvent the people who plan and manage the health and hunger of this nation and its neighbors. They have failed us during the past 50 years. The illustration of the HIV epidemic in India is case-symptom of the malaise of public health in India. In many countries they have resolved the HIV epidemic from a panic to an almost manageable situation while we are yet to put into place even the elementary interventions in place during the last decade and half.

p) For non-governmental donor-partners it is likely that donors may be forced to funnel resources into one officialised basket.

The anachronism of the F.C.R.A. and globalisation has been discussed variously, but the national phobia of militancy, separatism and now religious conversion aided by "foreign funds" will not be replaced by saner phobias. The other fact that needs to be elicited is the efficacy and the ethics of NGOs and NGO networks.

The model of brokering development versus the model of community- initiated change and growth needs to be dialectally viewed. Maybe the procedure of support for projects and programs which exclude the constituency from the process of planning needs to be intensely questioned. The belief in institutionalizing change through NGOs with high capital investments needs to be requestioned after 3 decades, in India at least.

Funding of research on communities and social groups through NGOs or other official agencies, needs discrete parameters and ethical contracts with specified mechanisms for redress in the contract. The veneer of 'public good' is not sufficient and acceptable. ■

18 Comments on "Case Study of World Bank Activities in the Health Sector in India"

Ravi Narayan

The Sector and Thematic Evaluations Group and the Operations Evaluation Department of the World Bank (India) prepared a case study* on the World Bank's Health-Nutrition-Population programme in India based on review of literature, sector and project documents and the proceedings of the workshop on "The World Bank's Role in the Health System in India" which included 9 papers commissioned by OED.

This note by some of us from the Society for Community Health Awareness, Research and Action, Bangalore, a multi-disciplinary professional resource group working for the last 15 years supporting community level health action and community oriented health policies by the voluntary sector and government, brings to hear comments on this case study from a Public Health, socio-epidemiological; management; ethical; and public policy perspective-which are the disciplines represented among the four member group of the society, who studied the document.

* See Report No. 19537, Case Study of World Bank, Activities in the Health Sector in India, June 29, 1999.- Sector and Thematic Evaluation Group, Operation Evaluation Department.

We had a little over a week to study this document and in spite of a request were able to get copy of only one of the nine commissioned papers! So our comments are based on a rather rushed analysis of the document handicapped by the absence of access to the background papers from which much of the perspectives and conclusions included in the case study, are drawn. Notwithstanding this constraint we hope the concerns we raise will be taken seriously by the Ministry of Health and Family Welfare and the World Bank India operations team. We believe these are concerns that we along with so many other public health/community health/health policy resource groups have been raising for over two decades now, but we are emboldened once again to do so-because for once the findings of this case study so strongly endorse and support them. These comments are also based on insights that we have with involvement with World Bank projects at Karnataka State levels in various ways.

We believe it is time that the Ministry of Health and Family Welfare at the Centre and State and the International funding partners, particularly the World Bank ('who is now the largest lender in health, nutrition, and population with the largest programme in India') - who jointly conceive, conceptualise, operationalise and monitor such large collaborative projects on behalf of the people of this country - (emphasising "poor and undeserved and concentrating on children and mothers") took these concerns seriously.

This significant, rather short, but important Consultative Meeting could be serious step in that direction. However, a more detailed dialogue is required if these concerns must get translated into constructive policy change.

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COMMENTS

The Case Study of World Bank Activities in the Health Sector in India brings together findings from a variety of sources (mostly World Bank commissioned) and attempts a comprehensive, critical, historical view of 23 projects undertaken by the Bank in partnership with the Ministry of Health and Family Welfare at Central and State levels and to which the Bank "contributed over $2.6 million plus studies and policy dialogue".

The case study is frank, introspective and 'as objective as possible under the circumstances'. Though inadequately referenced even from the commissioned

studies, and perhaps representing sets of opinions rather than 'evidence based analysis' it is still a sobering indictment of what the Bank claims to be the "largest Health Nutrition and Population programme" funded by it.

Appendix 1 of this note lists out in the report's words key findings and conclusions producing **a rather disturbing, disconcerting scenario and a rather frank admission of failure, and distortion. If a SWOT analysis were to be done on the case study – then weaknesses would far outweigh the strengths; and threats/ distortions far outweigh the opportunities!**

In the absence of access to all the commissioned studies and reports/ documents quoted in the report, it would be unfair to attempt a comprehensive review of the document, but we raise the following comments, reflections and questions from a Public Health; Epidemiological; Management; Political Economy; Public Policy and Ethical perspective, keeping an overview of the overall partnership between MOHFW and the World Bank in mind and not addressing just the nitty gritty. Some of these are endorsed in the case study. Others are derived from the findings presented.

1. Public Health Devalued

The whole partnership suffers from a disturbingly lack of 'public health' competence and perspective and this chronic lacunae does not seem to have been overcome even when the claim "the Bank is now on the right track" is made.

Throughout problem analysis, project planning and formulation, there is a confusion between

- Public health system and public health care system

- Between socio-epidemiological context of a problem and its economic or techno-managerial context, the latter taking precedence over the former every time.

- The wider determinants of health status that need to be addressed by good public health is totally ignored (devaluation of nutrition is admitted but other aspects like water supply and sanitation, transport and communication, environment pollution have not been addressed and even health education in this report is put outside the confines of the health sector.

- The focus on the poor, the indigent and the marginalised which should be the central focus of an equitous public health system is ignored or if present in programme focus is

ignored in programme implementation.

- In fact both 'epidemiology' which is the sheet anchor of public health and 'political economy' which should be a important part of problem analysis is totally ignored.

- The regional diversities and differentials-now known for a long term are ignored.

Between the generalist administrators who now manage India's Health System and the 'economist and programme managers' that advise them from among the Bank's staff and Consultants Public Health has been totally devalued and distorted both due to a lack of public health orientation and public health competence among the policy makers concerned.

2. *Primary Health Care Sidelines*

The World Bank projects evolved and developed when the country began to take the Srivastava (1974) and Kartar Singh report (1973) seriously; commissioned the ICSSR/ICMR Health for All: An Alternative strategy document (1981) after becoming an enthusiastic signatory of the Alma Ata declaration; enunciated the National Health guidelines of 1982; the National Education Policy of 1986 and the National Education Policy for Health Sciences in 1989. In addition, the ICMR initiated its review of Alternative Approaches in Health Care (1976) and the Evaluation of Alternative Primary Health Care (1980). Preceding these documents but supplementing/complementing them, there was a spate of micro-level and collective initiatives in Alternative Health Care in the 1970s and 1980s which are now well documented and a host of very incisive, evidence based, though provoking analysis of India's health care systems from social, economic, cultural, politics, epidemiological and public policy perspectives from the mid 1980s to date. The World Bank project partnerships seem to be totally 'uninformed' about all this and has not only ignored the Primary Health Care mandate but has actively distorted the Primary Health Care agenda by focussing on.

- 'selective, cost effective treatment schedules' rather than enabling/ empowering health care processes.

- Relying only on the now well debated and well established inadequacies of the GBD study based on DALYS (WDR -93 and the documents that followed)

- Focussing now on secondary hospitals rather than primary health care.

- On first referral units rather than the Primary Health Centres.

- Totally neglecting the people and community, whose involvement at all

levels was envisaged by the Alma Ata commitment and 'whose needs/ capacities/aspirations were to be emphasised' and not made subservient to needs of technology or the exigencies of top down management systems.

- Finally, it ignores Panchayatraj, which has to be the focus of Public Health and Primary Health Care in the 1990s (even cautions against it) and then creates Registered Societies as a decentralisation initiative without clarifying how they will be made accountable, transparent, responsive to public need or the country's democratic political system.

3. *Unconstitutional Partnership*

The World Bank seeks to influence/health policy in India by

(a) virtue of being the largest lender to the sector, even though there is enough evidence that this forms a small part of the entire country's budget;

(b) by various conditionalities that overrule local expertise and project formulations

(c) by thrusting on the country ideas from rather different countries with different social, economic, cultural, political, ecological and epidemiological context. (All example from Malaria Control will be given to substantiate this)

What is the 'Constitutional validity' of this leverage which is greatly enhanced by use of 'funding muscle?' and which was established during a period of economic vulnerability of the country ('The big break' mentioned in page 18).

Considering that many of these are loans and not grants, is the World Bank willing to bear the costs of failure and distortions due to poor programme planning that ultimately affect the poor the most?

What is the long-term sustainability of such a leveraged process – often arrogant, top down and externally inspired. What is the effect on local health system capacity development?

Is it not leading to coercion? Distortion? Competition? Who will bear the responsibility? What is the accountability and transparency especially to civic society?

The MOHFW must seriously dialogue on these issues before the PAC, the legal system, the political system and civic society begin to question and initiate informed citizens' action against it. In Karnataka this process is already starting up.

4. *Ethical Issues*

The case study raises some major ethical issues

a) What are the **'ethics'** of promoting so enthusiastically the 'private sector' when there is no evidence even from Bank sources that the private sector either has the capacity to provide 'low cost effective quality care' or has any commitment to 'public health' or to the goal of equity (giving only the example of Apollo, Chennai, which is not even among the best examples of corporate social responsibility is a case in point).

b) What is the **'ethics'** of undertaking a partnership taking the credit when there is success and then pointing a finger at the MOHFW when problems are identified and not solved (the report calls the World Bank position 'cautious' but 'incompetence' is what the report establishes). Does this make World Bank an unreliable partner?

c) What is the **'ethics'** of continuing to fund even after 1990 – a programme, when the Bank is well aware of the flaws and distortions?

d) What is the **'ethics'** of expanding 'quantity' at the cost of 'quality' or 'infrastructure' at the cost of 'services focussing on the poor'.

Is it at all surprising that ever since the World Bank has become a lender of large amounts of money – that the medical scams in the country have also gone up? There may be no cause-effect relations but why does the report ignore corruption which is endemic in the country; is now well documented by civic society; and is well accepted in problem analysis; by serious policy researchers.

Has the World Bank ignored it by oversight? Is it aware that it may be inadvertently supporting it or even facilitating it – international tenders and guidelines not withstanding?

5. *Management Issues*

In terms of 'Management' perspectives, it is rather surprising that a partnership that claims to be able to marshall international expertise has continued to:

i. Develop infrastructure quantity rather than quality.

ii. Expected 'training'; inputs to get over needs of management reforms.

iii. Given so little thought to accountability and transparency.

iv. Relied on internal monitoring/ evaluation by in-house staff and consultants rather than independent credible external evaluation.

v. Ignored health human power management issues.

vi. Focussed only on 'userfee' rather than diverse fund enhancing options including health budget increase/

vii. Given so little thought to ownership.

Directorate of Health Service staff at all levels often feel coerced by the conditionalities/guidelines and lack of flexibility, and do not identify with it. There is also nil ownership at the community/civic society level.

(This is probably the greatest failure of the World Bank projects and both MOHFW and World Bank partnership cannot overlook this any longer).

All this may be changing now-the case study claims –but is this real change understood at core policy level?

6. *Political Economy*

The case study does not look adequately at the larger 'political economy' issues against which the analysis and the successes and failures should be contextualised. These include the financial situation in the country and globally: the reduction/stagnation of public sector budgets; the impact of rise in prices on drugs/diagnostics; the contraction of public sector; the expansion of private sector under LPG (Liberalisation, Privatisation and Globalisation) and its impact on public health and access by poor to medical care, the potential impact of WTO and changes in Patent laws; the increasing corruption and scams, etc., and there by the policy researchers involved in the partnership constantly under-estamte the political, social, institutional and other dimensions of the problem analysis and hence offer recommendations that are general and not focussed on 'how and why things run' or 'do not run'. The report admits this and hope the next phase will address it. While this may be changing, of late s it still on the sideliens of the partnerships planning and problem solving efforts and depends very much on the quality and experience of consultancies and in-house expertise that is facilitated both inside the MOHFW and the WB-India office.

Unless there is a strong 'public health policy resource group within the MOHFW' in the next phase and this fee-lancing, free floating, adhoc consultancies and commissioned studies are institutionalised a real change in competence may not take place. The report established rather well the inadequacies of the last two decades but its chapter on implication for the future or how to develop an effective programme fails to grasp the complexity of the situation. One does not know whether this naievity is intentional or inadvertent?

7. *Building on Strengths and New Insights*

While the above 6 comments may seem to focus mainly on weaknesses and distortions that have plagued the framework of the World Bank Project partnerships, we do also recognise some strengths and especially some of the new insights in the report which we hope will find increasingly higher place on the agenda of problem analysis, project formulation and project management in the future.

Some Strengths

i. By focussing on 'private sector' even though on the 'profit' rather than 'non-profit' and 'corporate' rather than 'general practice', that Bank has brought into policy focus the engagement with the private sector which has long been a 'blind spot' in Indian health planning. It is time the GOI/MOHFW studied this sector recognised, monitored, involved, regulated, evaluated and 'quality assured' in this sector.

ii. It has more recently supported the target free approach and the shift from Family Planning, especially sterlisation, to Mother and Child Health (RCH) but still has a long way to go towards women's health and development.

Some New Insights

iii. It has also identified the following new thrusts in its section on policy implications which are welcome.

- *"need to focus on staff policies and practices regarding compensation assignment, transfer, promotion and demotion work rules and supervision".*
- *"need to take more account for field conditions and to find solutions to implementation problems".*
- *"need to ensure that basic, simple services for the poor are not neglected in the wake of attention paid to secondary hospitals.*

All these are definitely steps in the right direction. In addition, we believe that if the points 1-7 are considered not as negative judgements but as stimulus to change track and be rooted in local social reality than these will add to important policy change as well.

8. Some of blind spots continue even after two decades of work in India

à) One is especially striking and that is the total disregard of Indian and alternative systems of medicine and folk health traditions, in spite of the country having such a large network of institutions, health centres and human resources in these systems.

b) Is the total lack of understanding of people from a social/community point of view. Reducing everyone to a potential patient, client or stakeholder and taking about social marketing through IEC rather than community involvement in planning, organising, monitoring and evaluation continues and is another major lacunae.

9. Our comments do not attempt a response to all the nitty gritty. In Appendix 2, we list out an alternative framework of reference-a paradigm shift that is seriously required if the World Bank and MOHFW want really to be on the right track. The Bhore Committee recognised it in 1946; the WHO through Alma Ata in 1978, GOI in 1982 through the NHP; and the ICSSR/ICMR earlier in their Health for All report in 1981.

How long can the poor and marginalised in our country wait for this shifrt to take place in World Bank thinking. IN the 1999, there is a some possibility – as seen in this report. Will 'peoples health' needs finally prevail over the 'market economy of health'? Will ethical concern for health of the poor prevail over neo-liberal economics? Will the World Bank partnership with MOHFW be willing to make this paradigm shift? ■

CHAPTER 6 - ANNEXURE - 1

STATEWISE TRENDS IN REAL PER CAPITA EXPENDITURE ON RURAL DEVELOPMENT AND EMPLOYMENT AND SOCIAL SERVICES

State	Rural Development and Employment					Social Services					Human Priority Expenditure				
	I	II	III	IV	V	I	II	III	IV	V	I	II	III	IV	V
Andhra Pradesh	7.06	19.56	28.41	26.96	28.59	70.75	112.4	137.32	120.81	121.8	32.21	59.25	78.43	68.91	70.3
Assam	2.87	6.8	11.23	13.17	12.77	65.24	94.87	125.97	127.11	146.18	31.87	50.68	77.25	82.62	89.63
Bihar	28.31	28.76	27.09	20.82	17.37	34.43	65.67	77.98	101.45	86.64	-	98.17	79.68	61.42	49.95*
Gujarat	8.35	23.15	25.16	29.71	24.44	84.54	123.04	168.66	176.07	181.16	46.32	71.8	103.93	110.09	106.09
Haryana	6.79	14.52	19.75	19.65	13.03	76.11	120.27	177.27	185.32	188.76	36.34	64.64	89.95	90.27	83.26
Karnataka	4.47	13.53	19.85	24.66	26.22	77.38	97.25	147.91	152.67	170.08	42.51	60.3	82.3	83.9	86.42
Kerala	5.09	13.79	14.96	18.79	15.74	122.94	131.86	164.4	190.55	195.2	61.58	66.82	80.96	102.13	87.53
Madhya Pradesh	4.84	14.22	16.79	22.35	23.43	65.31	82.68	109.09	118.84	123.03	34.04	52.53	69.86	77.67	79.4
Maharashtra	11.4	18.6	23.38	15.49	31.02	95.25	126.3	172.25	185.57	202.06	52.2	73.42	96.99	86.44	86.36
Orissa	6.72	13.83	20.09	25.91	25.15	74.46	99.2	116.03	120.56	136.53	36.28	48.72	75.07	80.48	83.24*
Punjab	2.88	10.04	10.23	5.69	4.63	97.85	137.7	207.61	198.55	177.9	40.75	62.93	72.64	71.56	65.26
Rajasthan	9.39	14.3	30.78	24.88	21.46	78.74	93.78	124.13	156.3	162.61	46.77	59.48	93.42	103.2	99.1
Tamil Nadu	13.68	19.5	16.98	22.18	20.43	103.34	121.44	155.85	201.43	201.03	51.59	69.12	79.09	103.81	102.56
Uttar Pradesh	4.39	13.41	20.11	31.34	24.92	47.24	69.65	89.33	113.25	100.58	29	46.18	62.19	92.48	71.83*
West Bengal	4.48	7.27	15	21.57	20.78	79.44	109.36	121.12	156.28	147.91	27.99	38.74	51.72	68.05	62.64
Mean	8.05	15.42	19.9	21.54	20.67	78.2	105.7	139.66	153.65	156.1	37.96	61.52	79.57	85.54	67.9
Std. Dev.	6.17	5.58	5.87	6.34	6.71	21.03	21.22	34.14	33.31	35.4	13.75	13.7	12.79	14.27	35.98
C.V.	76.65	36.21	29.39	29.42	32.45	26.9	20.08	24.45	21.68	22.68	36.21	22.27	16.07	16.68	52.98

Notes: I - indicates 1974-5 to 1978-9 - V Plan, II - indicates 1980-1 to 1984-5 - VI Plan, III - indicates 1985-6 to 1989-90 - VII Plan, IV - indicates 1990-1 - Pre-adjustment Year, V - indicates 1991-2 to 1995-6 for Social Services and 1991-2 to 1993-4 for Rural Development and Human Priority Expenditure indicates post-adjustment period, * - indicates 2 year averages.

Source - cited in Prabhu (1997): Reserve Bank of India, Finances of State Governments NIPFDP data bank.

Reference: Chelliah R.J. and R. Sudarshan "Income Poverty and Beyond-Human Development in India" Social Science Press; New Delhi; 1999 (pp.154-55).

CHAPTER 6 - ANNEXURE - II

STATEWISE EXPONENTIAL GROWTH RATES IN REAL PER CAPITA REVENUE EXPENDITURE ON SOCIAL SERVICES

States	Overall	Before break (%)	After the break (%)	Year of Shift (%)	Nature of Shift
Andhra Pradesh	3.45	8.36	-1.47	1984-85	Downward
Assam	4.82	6.29	2.27	1986-87	Downward
Bihar	9.25	12.28	2.39	1981-82	Downward
Gujarat	4.67	6.37	0.71	1987-88	Downward
Haryana	5.66	7.38	0.21	1988-89	Downward
Karnataka	5	5.84	2.33	1988-89	Downward
Kerala	2.85	2.32	12.85	1992-93	Upward
Madhya Pradesh	4.05	4.85	1.51	1988-89	Downward
Maharashtra	4.62	5.52	3.05	1986-87	Downward
Orissa	3.74	26.37	3.2	1975-76	Downward
Punjab	4.05	6.55	-3.91	1988-89	Downward
Rajasthan	4.44	-6.03	5	1976-77	Upward
Tamil Nadu	4.27	2.79	4.73	1980-81	Upward
Uttar Pradesh	4.7	5.74	-2.18	1990-91	Downward
West Bengal	3.81	9.04	3.02	1978-79	Downward

Source: Prabhu (1997).

Reference: Chelliah R.J. and R. Sudarshan "Income Poverty and Beyond - Human Development in India" Social Science Press;
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INTERNAL WORKSHOP REPORTS

1. Summary Note of Discussion with Partners on Perceptions from the Field in the Political and Social Context, 1999.
2. Summary Note of Discussion with Partners and Non-Partners on Economic Policy and Credit, 1999.
3. Social Role and Impact of Cinema: Opportunities, Challenges, and Limitations in the Present Context, 2000.

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LIST OF HIVOS POLICY PAPERS

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2. Environment: Gaining a Foothold Hivos and Sustainable Development, May 1999.
3. Memorandum on Policy Implementation Gay and Lesbian Emancipation, February 1999.
4. Hivos in Asia Policy Framework 1999-2002, May 1998.
5. Greater Equality of Opportunity on the Markets, December 1996.
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9. Culture and Development, January 1995.
10. Hivos and Population – A Survey.
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12. Hivos in the Third World, Full Participation: A Question of Power, November 1988.
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ANNEXURES

1. Manual for Supporting Economic Activities, June 1996.
2. Co-Funding, Concept, Issues and Guidelines (Internal Document), February 1992.
3. The Question of Good Governance, January 1992.
4. Memorandum on Loans, the Financing of Economic Activities, March 1989.
5. Discussion Paper on Seed Capital Package for Financial Institutions, May 2000.

HIVOS REGIONAL OFFICE, BANGALORE

Hivos (Humanist Institute for Co-operation in Developing Countries, The Netherlands) is a secular humanist development institution which stands for emancipation, democratisation and poverty eradication in developing countries. It was established in 1968 by representatives of the Humanist movement in the Netherlands. Hivos is inspired by the humanist, and secular outlook. Hivos co-operates with Non-Governmental Organisations (NGOs) which work on the basis of participation and self-reliance of the poor, aim at structural social change in a non-dogmatic way, and can translate such objectives into a coherent development programme.

Hivos' involvement in India with programme partners started in 1979. Hivos Head Office with support from local consultants managed the programmes. In March 1991, the first Regional Office was established in Bangalore in an effort to bring Hivos 'closer to the field'. The work of the regional office includes enhancing its monitoring capacity (more systematic and planned interventions); streamlining the programme in the tribal belt; identifying a number of partners who come into the policy spearheads of economic activities, environment, women in development, culture and HIV/AIDS. In the sectors of economy and culture separate funds have been set up vis-à-vis the Hivos Triodos Fund and the Hivos Culture Fund.

Today Hivos' programmes are concentrated in the three southern states of Karnataka, Andhra Pradesh and Tamil Nadu and in the tribal belt which stretches from Gujarat and Rajasthan in the West, via Maharashtra and Madhya Pradesh in the centre, to Orissa and Bihar in the east of the sub-continent. A small number of partner organisations with a regional or national focus are located in the major urban centres of Bangalore, Madras, Hyderabad, Bombay and Delhi. Apart from its various primary functions listed above the regional office has stimulated discussions on a number of policy issues by means of seminars, smaller consultations and publications. Workshops have been organised on HIV/AIDS as a human rights issue, accounting systems, co-operatives, women in development, reproductive health, development policies in the '90's, and the impact of structural adjustment policies on the poor. The workshops were often very collaborative processes done with national organisations and NGOs. The publications listed come under the Hivos Technical Report Series which has a wide circulation in India and abroad.

Hivos has reaffirmed its choice for concentrating on two main population groups in India: The dalit population and the several indigenous (tribal) people. The emancipation of the minorities and that of women is perceived not in isolation but well grounded in also working towards creating a receptive environment within the country - by reinforcing secularism, pluralism, and democracy. In order to contribute effectively to the strengthening of a civil society in India, Hivos partnerships with NGOs that function as public interest institutions with regard to human rights (including civil rights), and initiatives that critically influence the media. Hivos continues to work mainly in the rural areas. Hivos as an institution believes in integrating policy focus with quality programme development, placing high on its list issues of accountability, long-term goals of social equity and sustainability.

As one of the four Dutch Co-Financing agencies, Hivos derives a large part of its funds from the Co-Financing budget line of the Dutch Ministry for Development Co-operation. Hivos' total expenditures for 1999 in India amounted to Dfl.9.6 million. These are inclusive of EU, additional and other funds.

Hivos

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